

# SUPPLEMENT TO THE BRITISH MEDICAL JOURNAL

LONDON SATURDAY APRIL 20 1946

## British Medical Association

### ANNUAL REPORT OF COUNCIL, 1945-6

*Every member is asked to keep this Supplement, which contains matters referred to Divisions, until the subjects have been discussed by his Division*

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#### PRELIMINARY

1. The membership of the Association continues to show a very satisfactory increase. The membership figure at December 31, 1945, was 51,508.

The Roll of Honour includes the names of 10 medical officers killed on active service, and 20 who have died on active service. The Association has also to deplore the deaths of 535 members.

#### President of the Association

2. The Council recommends:

**Recommendation:** That Mr. H. S. Souttar, C.B.E., D.M., M.Ch., F.R.C.S., F.R.A.C.S., be elected President of the Association, 1946-7.

#### The Secretariat

3. As successor to Dr. R. W. Craig, the Council has appointed Dr. E. R. C. Walker of Aberdeen to be Scottish Secretary.

The Council has appointed Dr. E. E. Claxton (Sutton Coldfield) and Lieut.-Col. D. P. Stevenson, R.A.M.C., as assistant secretaries to the Association. Dr. A. V. Kelynack, who was appointed a temporary assistant secretary in March, 1944, has now been appointed a permanent assistant secretary.

The A.R.M., 1945 (Minute 105), referred to Council for consideration a proposal for the appointment of an assistant secretary for Scotland. After reviewing the position the Council decided that it was unnecessary to make such an appointment at present.

#### Annual Representative Meeting

4. The Annual Representative Meeting will be held on Tuesday, July 23, at 2 p.m. The meeting will continue on Wednesday and Thursday, July 24 and 25, and, if necessary, on the following day.

#### A Charter for Health

5. The publication of *A Charter for Health* has been delayed by various trade difficulties, but the book is now complete and will be published this month. It will be on sale through the booksellers, price 6s.

#### Reports on the Nation's Health

6. The Council was requested by the A.R.M., 1945 (Minute 136), to consider every possible means of instituting collaboration between the Association and all medical bodies producing

reports concerning the nation's health before such reports are published. It decided after consideration that there was no need at present to take any special steps in the matter.

#### The Care of Homeless Children

7. The Memorandum of Evidence on the Care of Homeless Children referred to in paragraph 68 of the Council's Supplementary Report for 1944-5 has been completed and submitted to the Interdepartmental Committee on the Care of Homeless Children. It was supported by oral evidence. The Memorandum has been printed in pamphlet form and copies may be obtained by members on application to the Secretary.

#### The Medical Curriculum

8. As was stated in paragraph 9 of the Council's report for 1944-5, a special committee has been appointed to review the medical curriculum in the light of later developments and the requirements of modern practice. The committee has devoted its first few meetings to the pre-university education of the medical students and to the premedical subjects of the first-year course. It believes that the reform must be a good deal more radical than is usually admitted, and it is accordingly making a thorough re-examination of the curriculum as a whole, and is reviewing the approach to medical education and the teaching methods adopted. The Committee will take into consideration Minute 23 of the A.R.M., 1945, which suggested that the committee should "investigate the part which general practitioners can take in the medical education of the prospective general practitioner."

#### International Relations

9. The Council has considered the means of implementing the decision of the Conference, held in June, 1945, to hold in 1946 a conference representative of the national medical organizations of the different countries. Considerable difficulty has been experienced in making contact with some of the organizations in Europe, and they were evidently not ready for a conference in the early part of the year, as had been hoped. The conference will now be held at B.M.A. House from the afternoon of Wednesday, September 25, to the morning of Friday, September 27. About 45 invitations are being sent to national organizations, including the B.M.A. organizations in the Dominions. The purpose of the conference is to consider the

formation of an international medical organization with the following objects:

- (i) To undertake an exchange of information on medical affairs;
- (ii) to promote closer ties among the different national medical organizations;
- (iii) to encourage better international relations generally by personal contact and otherwise;
- (iv) to embody, continue, and extend the work formerly undertaken by the A.P.I.M.

The Council is also obtaining information about the appointment and duties of Health Attachés in accordance with Minute 26 of the A.R.M., 1945.

#### Psychiatry and the Law

10. The Committee on Psychiatry and the Law, established jointly by the Association and the Magistrates' Association (see paragraph 54), has considered the Criminal Justice Bill and suggested certain amendments. It will be remembered that this Bill was originally introduced into Parliament in 1938 and dropped at the outbreak of war. It is understood that steps are being taken to revive the Bill, which contains some important provisions for the medical examination and treatment of offenders. The committee has also under consideration the question of the provision of psychiatric observation centres, especially for juvenile offenders, and the problem of the unstable adolescent girl.

#### Group of Dermatology

11. A Group of practitioners engaged predominantly in the practice of dermatology has been formed within the Association. The first conference of members of the new Group was held on March 21.

#### A Suggested Group of Homoeopathy

12. The Council considered a petition from certain members for the formation of a Group of Homoeopathy. While it sympathized with the desire expressed that medico-political problems specially affecting homoeopaths should be considered by the Association, it was of the opinion that the conditions were not such as to necessitate the formation of a special group. It has, however, assured the Faculty of Homoeopathy that it will consult it on any matters affecting the interest of homoeopaths, especially in relation to the proposed National Health Service.

#### Medical War Relief Fund

13. The A.R.M., 1945, recommended (Minute 42) that an appeal should be made for generous contributions to the Medical War Relief Fund. An appeal for £100,000 was published in the *Journal* on December 1, 1945, and the Council asked Divisions to organize local appeals. Up to April 5 the subscriptions received amounted to £73,656.

#### Protection of Practices Scheme

14. With the end of the war and the demobilization of medical officers protection of practices schemes are coming to an end, and the Council will shortly publish a survey of the work of the local committees which have been responsible for the administration of the schemes.

#### Demobilization

15. The A.R.M. (Minute 152) expressed dissatisfaction with the demobilization scheme and urged that pressure be brought upon the Service Departments to release more doctors. Every possible step was taken by the Council and by the Central Medical War Committee to persuade the Government to accelerate the demobilization of medical officers, and the Council believes that the present position, so far as it relates to the release of general duty officers, is now generally regarded as satisfactory.

#### Representation of R.N. Medical Service in Council, 1946-9

16. The Council recommends:

**Recommendation:** That Surgeon Rear-Admiral W. H. Edgar, C.B., O.B.E., M.D., be elected to represent the Royal Naval Medical Service on the Council for the three years 1946-9.

#### National Health Service Bill

17. The Government's Bill to provide for the establishment of a comprehensive health service for England and Wales was published on March 21. On the same day the Council issued to every member of the profession, whether a member of the Association or not, a copy of the Government's White Paper describing the provisions of the Bill, a statement by the Negotiating Committee on the Principles of the profession, and a copy of the Council's report on the Bill. The latter was published in the *British Medical Journal* on March 30 (p. 469). A Special Representative Meeting to consider the Bill will be held on May 1 and 2, 1946.

#### PUBLIC RELATIONS

18. With the publication of the National Health Service Bill the public relations of the profession were directed to the task of explaining to the public the effect which the Bill would have on the individual patient. Attention was concentrated on three main points: that the profession had long wanted complete health provision and had its own plans; that it was in the patient's interests that the independence of the family doctor should be preserved; and that, although the adoption of regional organization in the hospital sphere was, in itself, a step forward, the expropriation of physical ownership of all hospitals by the State was unnecessary and must lead to a loss of local interest.

A "first reactions" press conference was held by the central committee on "B-Day," and a fuller conference, to which the Council's report on the Bill was made available, on the following day. Many Division public relations committees held their own local press conferences either at once or during the following few days. Some three weeks after "B-Day" it became apparent that the profession's opposition to certain features in the Bill was being interpreted in too many quarters as opposition to the idea of complete health provision as such; and emphasis was accordingly shifted to an increased extent to those points which, in the public interest, should be changed, and to the positive proposals of the profession. From the beginning detailed suggestions as to local action were circulated to all Divisions, and at the same time Division public relations committees were encouraged to act on their own initiative. The morning session of the Conference of Secretaries, held at B.M.A. House on April 4, was devoted to public relations and proved helpful both to Divisions and Headquarters. It was pointed out that local activities culminating in pressure on local M.P.s were of paramount importance.

The help of the Public Relations Committee was enlisted in securing attention for the *Charter for Health*, publication of which helped to emphasize the breadth of the profession's interest in health problems. The film illustrating the work of the family doctor, in the production of which the Association had co-operated, became available for public distribution during March.

The committee considered Resolution 24 of the A.R.M., 1945, requesting Council to prepare and publish a concise pamphlet on health which would be available to the general public at a small charge, and decided that it was inopportune at the present time to produce a further pamphlet on the general subject of health, but that the committee should consider the issue of pamphlets or leaflets on particular health problems as they arise.

In view of the many calls on the committee's funds an increase in expenditure during the year up to a total of £25,000 has been authorized by the Council of the Association and the Trustees of the National Insurance Defence Trust.

#### HOSPITALS

##### "General Practitioner" Hospitals

19. The Annual Representative Meeting, 1944, adopted the following resolution:

"That this meeting urges the importance of the preservation and development of the small general hospitals and recommends to the Council that it gives its earnest consideration to making these hospitals staffed by general practitioners the nuclei of one type of the future health service centres."

The Council submits in Appendix I a report on this matter.

**Recommendation:** That the report on "General Practitioner" Hospitals be approved.

### Co-operation with other Professional Bodies

20. The present constitution of the Hospitals Committee provides for the appointment of a member nominated by the Medical Superintendents' Society. The co-ordination of action on matters of policy affecting the interests of this Society and of the Association has been discussed and the following agreement has been reached.

1. If the Medical Superintendents' Society desires to urge upon central or local authorities or other similar bodies any medico-political policy affecting the interests of public or private practice, or is consulted thereon by such authorities or bodies, it shall communicate its proposals to the British Medical Association before taking action.

2. If such policy or proposals are approved by the British Medical Association either in their original form or in an agreed amended form, all action consequent thereon will be taken by the British Medical Association, and the Medical Superintendents' Society will refrain from taking any further action.

3. If the proposals of the Medical Superintendents' Society are not approved by the Council of the British Medical Association, or if the Medical Superintendents' Society is dissatisfied with the form in which the Council of the British Medical Association is willing to take action thereon, the Medical Superintendents' Society shall be free to take action independently.

Two other professional bodies whose members are engaged in hospital work have expressed their willingness to enter into an agreement with the Association identical with that quoted above, on condition that they also are granted direct representation on the Hospitals Committee. These bodies are the Association of Municipal Specialists (whose members are specialists in the whole-time employment of local authorities and principally engaged in clinical work, pathology, or radiology) and the Association of the Honorary Staffs of the Major (Non-Undergraduate Teaching) Voluntary Hospitals of England and Wales.

The Council considers it desirable that there should be an agreement with these Associations to secure uniformity of action on matters of policy, and it proposes that each of these associations should be entitled to nominate one representative to serve on the Hospitals Committee. The appropriate recommendations for amendment of the by-laws are contained in paragraph 92 of this report.

### Chronic Sick

21. The Council has considered the inadequacy of the present institutional provision for the chronic sick, as revealed by the reports of the Ministry of Health regional hospital surveys. These patients are often accommodated in antiquated and unsuitable buildings originally designed for other purposes. The arrangements for their medical and nursing care and for the provision of occupational and recreational facilities leave much to be desired. There is great need for better classification of patients and, in particular, for making separate provision for the elderly and infirm, for the incurable, and for those who, with proper medical care, may be returned to normal living conditions. Perhaps the most urgently needed reform is the arrangement of a full diagnostic investigation of these cases before they are classified as "chronic." In the opinion of the Council such patients should pass through acute general hospitals before being referred to special institutions, and a proportion of them should be retained in the general hospitals for treatment. This is desirable not only in the interests of the patients but also in the interests of the education of medical students and of student nurses. The Council therefore approves in principle the suggestion that all general hospitals should accept, where practicable, a certain percentage of chronic sick cases. (See also paragraph 71.)

### Hospital Staffs

22. The Council has considered Minute 74 of the A.R.M., 1945:

"74. Resolved: That steps be taken to obtain the release of nursing and medical personnel and the direction if necessary of domestic help for the hospitals and nursing homes to deal with the civilian population."

The release of medical officers from the Services in Class A of the re-allocation of man-power scheme was greatly accelerated towards the end of 1945, as a result of a decision of the Government to reduce the ratio of medical officers to

serving personnel to two per 1,000. Having urged the desirability of a speedier release of nursing personnel, the Council received from the Ministry of Labour in November, 1945, particulars of the arrangements then in force. Provision had been made for the release in Class B of members of the Women's Auxiliary Services, not engaged in nursing duties in the Forces, who were willing to take up civilian nursing; of men with nursing experience who were not engaged in nursing duties in the Forces; and of nurses with special qualifications who were required to fill key posts. The Class A release programme provided for the release from the three Services of 5,770 nursing officers and members of voluntary aid detachments by Dec. 31, 1945, and a further 6,780 by June 30, 1946. A Government statement had been issued which made a particular appeal to nurses so released to resume civilian nursing as soon as possible. By means of publicity campaigns nursing was kept before the public mind as a priority employment of national importance, and, almost without exception, men and women wishing to take up nursing could obtain release from other forms of work in which they might be subject to control.

The Council reconsidered the position in January and, in view of the difficulties still experienced by hospitals, again urged the Government to accelerate the release of nursing personnel from the Forces. At the same time the Council represented to the Government that the direction of newly qualified nurses from the general hospitals to tuberculosis institutions should cease. So far as male nurses and male assistant nurses are concerned, the Council considers that the remuneration offered is not sufficiently attractive, and it has asked the Ministry of Health to arrange for the rates of pay to be reviewed.

As regards domestic workers, arrangements have been made for the release from the Forces in Class B of up to 1,000 women with experience in institutional cookery who are prepared to work as hospital cooks, and an appeal has been made to men and women demobilized in Class A who have training or experience in catering or domestic work to take up employment in hospitals. As a result of the restriction of the use of direction which followed the end of the war in Europe, it is necessary for employment exchanges to depend on persuasion rather than direction in supplying domestic workers to hospitals. Workers not employed in key posts are free to transfer to hospital domestic work if they so wish.

### Liaison with the Nursing Profession

23. The Council has considered it desirable to establish standing liaison arrangements between the Association and the nursing profession, and a joint committee consisting of representatives nominated by the Royal College of Nursing and the Association has been set up.

### Appointments to Consultant and Specialist Staffs

24. In July, 1939, the Council issued to hospital authorities, council and voluntary, a circular containing a number of recommendations designed to protect the interests of members of the consultant and specialist staffs who might be absent on whole-time Government service, and of other absent practitioners who might be eligible for new appointments. In particular, the Council recommended that during the war and for twelve months thereafter new appointments should be made on a temporary basis. In May, 1945, the Council repeated its 1939 recommendations, urging a continuance of the practice of making temporary appointments and recommending that, where exceptional circumstances were thought to justify a permanent appointment, applications from Service candidates should be explicitly invited and a period of at least four months allowed for the receipt of applications from Service candidates over-seas. In September, 1945, the Council took the further step of informing hospital and other employing authorities that advertisements of permanent appointments which did not comply with these recommendations would be refused publication.

The Council appreciates the very large measure of co-operation received from employing authorities in this important matter. It has lately reconsidered the position and decided that, in the interests of employing bodies and of the large number of demobilized doctors, it is desirable that the restriction on the making of permanent appointments should be removed. More-

over, as postal communication is now more rapid, the Council has come to the conclusion that the minimum period allowed for the receipt of applications from Service candidates can and should be reduced to two months. These changes of policy have been communicated to hospital and other employing authorities, and their attention has been drawn to the importance of re-advertising posts at present held temporarily when it is decided to fill them on a permanent basis.

One of the recommendations made by the Council in 1939, and repeated in May, 1945, was that "the period of war service of an absentee practitioner should be added to the age of retirement in respect of his hospital appointment(s)." It has been pointed out that a strict application of this rule might cause hardship by delaying unduly the promotion of junior members of hospital staffs who have themselves been absent on war service. The Council has therefore advised hospital authorities to consider methods of overcoming this difficulty. It has suggested, as one possible method, the appointment of "emeritus" members of the staff, occupying an intermediate position between the full appointment and retirement and enjoying the use of a number of beds without membership of the medical staff committee or other committees of the hospital.

#### Medical Staffs and Representation on Boards of Management

25. The Council has considered the question of representation on the Boards of Management of hospitals of members of the visiting staff who receive payment for their professional services, and has obtained counsel's opinion on the matter. The opinion of counsel was to the effect that, generally, payment from the funds of the hospital would debar a member of the staff from being a member of the governing body. The Council considers that this raises a very important point of principle, particularly in view of the proposed remuneration of the medical staffs of hospitals in the future health service. The Council has accordingly asked the Negotiating Committee to advocate such measures as may be necessary to preserve the right of the medical staffs of hospitals to be represented adequately on the Boards of Management, with voting power.

#### Payment of Staff for Ministry of Pensions Patients

26. The Council has considered the question of payment of visiting medical staffs of voluntary hospitals for the treatment of patients who are the financial responsibility of the Ministry of Pensions, and has recommended a payment of 4s. 6d. per patient per day, this fee not to be variable according to increases or decreases in the maintenance costs. The amount proposed is 25% of the payment for maintenance agreed between the British Hospitals Association and the Ministry for patients in non-teaching general hospitals.

#### REHABILITATION

27. In December, 1944, the Council appointed a special committee to consider the subject of rehabilitation. The committee has prepared a number of reports on different aspects of its subject, and arrangements are being made to publish in the *Journal* a comprehensive review of the problems of rehabilitation, comprising a factual statement of the present facilities for rehabilitation, an account of rehabilitation in the Services, the industrial resettlement of the neurotic, and suggestions for a planned rehabilitation service. Copies of this report will be made available for distribution.

#### The National Insurance (Industrial Injuries) Bill

28. The Council has considered the provisions of the National Insurance (Industrial Injuries) Bill, which is intended to supersede the machinery under the present Workmen's Compensation Acts. The Bill contains many provisions which were recommended by the Association in its report to the Royal Commission on Workmen's Compensation in 1940. The Council, however, represented to the Minister of National Insurance that the discrepancy between the rates of payment (45s.) for industrial injuries and the rates of sickness benefit (26s.) under the National Insurance Bill is likely to lead to an increase in the number of disputed cases and to social and economic difficulties which might retard rehabilitation in non-industrial cases. It urged that there should be a levelling up in the rates

of payment. The Minister expressed the hope that in the not too distant future it might be possible to bring into being a unified social insurance scheme, but in the meantime, since the Bill was one to replace the existing Workmen's Compensation Acts, the scales of benefit had necessarily to be higher than could at present be obtained under the National Insurance Bill, which was based on flat-rate contributions.

Further representations were made that if an injured person could not, by reason of his injury, be reinstated in his former employment, but could be re-trained for some alternative employment without loss of earning capacity, he should receive a flat-rate disability allowance while undergoing training; and also that if a person could not be reinstated in his own work and could not be trained for equivalent employment special financial provision should be made. The Council has observed that the Bill upon its third reading contained provision for the payment of an additional 20s. if the workman was permanently incapable of work, and an additional 11s. 3d. if permanently incapable of following his regular or equivalent employment.

The Council has also suggested to the Minister the establishment of a standing medical advisory committee, composed entirely of medical practitioners, to advise the Minister on the medical problems involved, including appointments to medical boards and appeal tribunals, and the assessment of prescribed industrial diseases. The Minister has announced his intention to set up a committee of medical and lay persons to examine the problem of scheduled industrial diseases, with a view to establishing and recommending a new criterion for inclusion in the schedule. The Council has considered the procedure under which applicants are admitted to the Register of Disabled Persons, and has expressed to the Minister of Labour its view that all cases should be examined by medical boards.

In its discussions with the Departments concerned the Council has reiterated and emphasized the opinion of the Representative Body that medical services in industry should form part of a comprehensive national health service, and that the Ministry of Health should be concerned with all civilian health services in which the Government is involved, and with none other.

#### GENERAL PRACTICE

##### Fees for Life Insurance Examinations

29. In 1919 an agreement was reached between the Association and the Life Offices Association concerning the fees for medical examinations for life insurance. The agreement provided: (a) for ordinary offices a fee of 21s. whatever the amount of the policy; (b) for intermediate offices a fee of 10s. 6d. for policies up to and including £100, and 21s. if over £100; (c) for industrial insurance a minimum fee of 5s.

In 1942 the Council urged the Life Offices Association to increase the fees by 20%, but the suggestion was declined. A deputation subsequently met representatives of the Life Offices Association, which still maintained that there was no justification for alteration of the 1919 agreement. There is a growing volume of complaint from members that the fees for this work are inadequate, and the Council has come to the conclusion that the 1919 agreement must be terminated.

**Recommendation:** That the agreement reached with the Life Offices Association in 1919 in regard to the fees for medical examination for life insurance be terminated.

**Recommendation:** (1) That for the purposes of life insurance there should ordinarily be a complete medical examination of the proposer and the fee for such examination should be not less than 2 guineas; (2) that, as it is recognized for the purposes of industrial insurance and for insurance policies for small amounts that a complete medical examination is not regarded as essential, the Association is prepared to agree to these arrangements provided a fee of not less than 10s. 6d. is paid for a modified examination and form of report.

##### Private Practice under 100% National Health Service

30. The Council (Minute 98 of A.R.M., 1945) was requested to give concrete proposals safeguarding private practice under a 100% National Health Service. So far as the matter relates to general practice the Council has reached the following conclusions:

1. That the principle of collective responsibility obtaining under the present N.H.I. scheme should not hold in the new service.

2. A general practitioner who contracts to give service under the National Health Service should be entitled as a right to accept patients as private patients. He should be entitled to treat privately any person who is not on his own list or that of any partner or assistant, whether on the list of another doctor or not. Where a practitioner has accepted a patient as a public service patient he shall be precluded from charging fees for any service he renders to that patient as a general practitioner.

3. A practitioner should be free to give such certificates, prescriptions, orders, or reports to his private patients as would secure for them any of the statutory benefits under the National Health Service.

4. Except in an emergency a general practitioner should not be required to treat as a public service patient any person: (a) not on his list; (b) who resides outside the area of his practice (as agreed by the local executive council).

5. A general practitioner should have the right to refuse to accept any person as a public service patient without giving reasons. Similarly, a patient should have the right, without giving reasons, to ask for the withdrawal of his name from a practitioner's list. A general practitioner should be entitled to ask for the removal of a patient from his list, without giving reasons, but he should give or continue treatment for a limited period until the patient is accepted by or is allocated to another practitioner. The interval for change of doctor (other than by consent) should be as short as possible.

6. Where a public service patient on a doctor's list desires to be treated privately by that doctor, the patient should be required, before being accepted as a private patient, to give due notice of the withdrawal of his name from the doctor's list.

7. A member of a partnership who elects to remain outside the service should not treat as a private patient any patient on the list of another partner in the firm. He should be regarded as a deputy in these circumstances; but this should not preclude him from treating as private patients those seeking his advice as a consultant or specialist.

8. Public general practice should be held to mean the treatment by the practitioner of persons on his list at the place appointed for the purpose—i.e., the health centre, the doctor's surgery, or the patient's home—but where public practice is conducted from the health centre private practice should be conducted at some place other than the health centre.

9. A patient should not be required to give official notification of his intention to obtain his general practitioner service privately. The doctor may obtain for his own use such evidence as he thinks desirable.

#### Resettlement Problems

31. For the purpose of carrying out the instruction of the A.R.M., 1945 (Minute 40), that all possible steps should be taken to assist medical officers demobilized from the Forces in their problems of resettlement, the Council has made special arrangements for interviewing and advising officers on demobilization, and a special booklet entitled *The Returning Doctor* has been prepared and issued to all demobilized doctors. Officers seeking advice about entering the field of general practice were put in touch with practitioners known, through notifications from Local Medical War Committees, to be in urgent need of assistance. Local Medical War Committees have been urged to form resettlement committees to help and advise doctors returning to their practices from the Forces.

#### Local Advisory Committees on Industrial Health

32. A circular letter is being sent to Divisions in connexion with the following Minute 55 of the A.R.M., 1945:

"55. Resolved: That the Association be instructed to promote the formation of local advisory committees on industrial health representing doctors, employers, and employees."

Divisions whose areas include industrial districts are being urged to promote the formation of local advisory committees on industrial health.

#### Supplementary Clothing Coupons

33. The Council has considered the following Minute 56 of the A.R.M., 1945:

"56. Resolved: That the Board of Trade be pressed for the provision of supplementary clothing coupons for medical practitioners and dispensers to cover the purchase of such items as operating gowns, surgeons' coats, and overalls."

In interviews with representatives of the Board of Trade the case for a concession for doctors and their staffs was pressed, but the Department's decision was that "it would not be possible to include doctors among the classes eligible for the 'industrial ten' without also including other categories—i.e.,

dentists, retail dispensers, hairdressers, and masseurs—for whom a strong case has also been presented. This would involve a large additional claim for coupons which could not be met while supplies remain so acutely short."

The Council does not feel that any further steps can be taken in the matter at the present time, but the decision of the Representative Meeting has been noted for suitable action when the supply position improves.

#### Joint Committee of Pharmacists

34. The Council has appointed representatives to confer with the Joint Committee of the Pharmaceutical Society on matters of common interest with chemists arising out of the proposed National Health Service.

#### Doctors' Cars

35. After Dec. 31 the Ministry of War Transport ceased to allocate priority for new cars by the issue of licences to purchase. The manufacturers, however, gave an undertaking that holders of permits should be dealt with in the order represented by the number on the licence. Every effort was made to issue permits against outstanding applications from doctors before the end of 1945. The manufacturers have given the Council an assurance that they will continue to give special consideration to the needs of essential users, but it is well known that production has fallen far short of expectation and it is impossible to avoid delay. Allocation of priority is actually in the hands of the main distributors within the quota allocated to them.

36. The A.R.M. passed a resolution (Minute 48) that steps be taken to obtain the abolition of purchase tax in connexion with doctors' cars. The question was raised with the Treasury in July, 1945, when the following reply was received:

"I am directed by the Lords Commissioners of His Majesty's Treasury to say that there is no provision in the law which would enable goods subject to purchase tax to be exempted from tax on the grounds that they have been sold to particular persons or are to be used for a particular purpose. It will be appreciated that if once an exception of this kind were made, it would be impossible to draw a line. It has accordingly been regarded as an essential principle of the tax that there should be no classes of consumers privileged to buy chargeable goods free of tax, and in these circumstances it is regretted that it is not possible to provide the relief from tax which you seek in respect of motor cars which are purchased by doctors."

The Council does not feel that the matter can usefully be pursued further.

#### Capitation Fee for Treatment of Ex-regular Firemen

37. The A.R.M., 1945, took exception to the clause in the agreement reached with the Fire Service Department of the Home Office concerning the capitation fee for treatment of ex-regular firemen which provided that for a fireman whose income did not exceed £420 per annum and who was in need of attendance when drafted from his home station the fee should be 3s. 6d. a visit, with a maximum of 14s. a quarter. The Council is glad to report that as a result of its representations the Department has agreed to drop this quarterly maximum figure and to increase the fee for a visit to 5s.

#### Requisitioning of Doctors' Houses

38. The Council has considered the following Minute 152 of the A.R.M., 1945:

"... that in order to facilitate their return, Council be instructed to take steps forthwith to prevent the requisitioning of absentee doctors' premises or, alternatively, to ensure that if the premises are requisitioned they shall be released in adequate time for the return of the absentee practitioner."

Cases raised by local committees and by individual practitioners relate to two main groups: (1) houses which have been requisitioned by the Services or by Government Departments; (2) houses which have been requisitioned by local authorities for "bombed-out" persons or for which a notice of requisitioning under new powers is threatened. Other difficulties relate to property which cannot be used for purposes of practice until more or less extensive repairs, decorations, etc., are carried out. The Council has referred cases in the first group to the Ministry of Health, which has in a number of instances been successful

in securing the release of the property. Cases in the second group are usually taken up with the local authority, and if this is not successful an appeal is made to the Ministry of Health. A reasonable measure of success in the present difficult housing situation has been achieved.

#### Disablement Advisory Committees and Panels

39. In connexion with the Disabled Persons (Employment) Act, 1944, there have been set up in each area advisory committees on which medical practitioners have been invited to serve. Each of these committees is advised by a panel, on which there is also a medical member appointed on a nomination of Local Medical War Committees. The function of the panel is to advise on the evidence submitted to it, and the medical member is not required to examine the individual applicant. The Council has made representations that the sessional fee should be 3 guineas for a session of not more than two hours with an appropriate allowance for mileage.

#### Standing Committee on Industrial Medicine

40. The A.R.M. in 1944 referred to the Council a resolution that "in view of the increasing importance of industrial medicine, this meeting recommends to the Council that it should consider the desirability of setting up a separate Standing Committee of the Association to deal with matters of industrial health."

On first consideration of this resolution the Council felt that it would be advisable to defer the establishment of such a Committee pending the reconstruction of the entire central committee machinery of the Association. It has, however, recently reviewed that decision because it is clear that it is not the Government's intention to include medical services in industry in the proposed National Health Service. The Council has come to the conclusion that it is now desirable to establish a Standing Committee to deal with all matters affecting the practice of medicine in industry. Its recommendation for the appointment and constitution of a Committee on Industrial Medicine will be found in paragraph 92.

#### Fees for Examining Surgeons under the Factories Acts

41. The A.R.M., 1944, referred to the Council a motion by the Torquay Division on the inadequacy of the fees of examining surgeons under the Factories Acts. The Council has discussed the matter with the Association of Certifying Factory Surgeons and has now made representations that the fees paid to examining surgeons should be increased as follows:

Form 71—certificate relating to examination of young persons	(Existing fee)
Where the examination is undertaken at the factory:	s. d.
7s. 6d. for first case .. .. .	5 0
5s. for each subsequent case .. .. .	2 6
Where the examination is undertaken at the practitioner's surgery:	
5s. per case .. .. .	2 6
Form 3—certificate of disablement—or form of comparable character which may be introduced under social security arrangements—10s. 6d. .. .. .	5 0
Where an additional copy of the form is required a fee of 5s. should be paid by the person requiring the form .. .. .	—
Form 190—Report of examining surgeon on conditions likely to arise in certain industries:	
(a) Fee for report and examination should be—	
£2 2s. for the first case .. .. .	10 6
and £1 1s. for subsequent cases where they arise in the same department of the factory and are dealt with at the same time .. .. .	5 0
(b) the mileage scale should conform to the scale agreed by the Ministry of Labour in respect of medical referees. .. .. .	
Examination of cases under the Dangerous Trades Regulations:	
5s. for first case .. .. .	2 6
2s. 6d. for subsequent cases .. .. .	1 0
Examination of Casual Workers under Pottery Regulations:	
5s. for first case .. .. .	} .. .. per case 1 0
2s. 6d. for subsequent cases .. .. .	

#### Fees to Civilian Medical Practitioners

42. As a result of action taken by the Council the fees paid to civilian medical practitioners for occasional attendance on Service personnel have been increased as follows from August 1:

	Rates before Aug., 1945	New Rates
	s. d.	s. d.
Attendance and medicine .. .. .	3 0	4 0
Day visit up to 2 miles .. .. .	4 6	6 0
Night visit up to 2 miles .. .. .	6 0	10 0
"Distance fee" for day or night visit for each additional mile or part of a mile over 2 miles (one direction only)	6	9
Fee for medical certificate .. .. .	—	1 0

The Service Departments were unable to agree to a refund to the practitioner where expensive medicines or drugs were provided.

The Council urged, in accordance with Minute 60 of the A.R.M., 1945, that in connexion with these services a night call shall be deemed to be one made between 8 p.m. and 9 a.m. The War Office has agreed that the night-visit rate shall be paid for a visit made between 8 p.m. and 8 a.m.

Medical examination of military personnel on release is normally carried out at Dispersal Centres, but the work is sometimes undertaken by civilian medical practitioners. As a result of representations by the Council the War Office has agreed to the following fees:

	£ s. d.
For an examination by a civilian medical practitioner not employed by the Department .. .. .	1 1 0
For an examination by a civilian medical practitioner employed by the Department on a capitation or daily rate .. .. .	10 6

The Department has suggested an overriding maximum for this work and this matter is still under discussion.

#### Fees for Medical Witnesses

43. The Council has made repeated representations to the Home Office about the inadequacy of the fees paid to medical witnesses in criminal cases. The Departmental Committee which was appointed before the war will shortly be reconstituted to deal with the matter and the Association will be afforded an opportunity of submitting its views to this committee. In the meantime the question of fees for medical witnesses in civil cases is being discussed with the Lord Chancellor's Department.

#### Composition, etc., of the G.M.C.

44. The Council has considered Minute 53 of the A.R.M., 1945, and has set up a special committee to review the working of the Medical Acts, with special reference to the composition, functions, and procedure of the General Medical Council.

#### NATIONAL HEALTH INSURANCE

##### Remuneration of Insurance Practitioners

45. The report of the Spens Committee on "what ought to be the range of total professional income of a registered medical practitioner in any publicly organized service of general medical practice" is expected to be published shortly. Without waiting for the report, an application has been made to the Ministry of Health for an increase in the insurance capitation fee, with effect from Jan. 1, 1946.

*Dispensing Capitation Fee.*—As the result of representations to the Ministry of Health the dispensing capitation fee has been increased from 3s. to 3s. 6d. per annum, with effect from Nov. 1, 1945. Consideration is being given to the adequacy of this increase in view of the heavy rise in the cost of drugs, etc. There is also dissatisfaction with the date from which the increase is effective. In the autumn of 1945 insurance chemists were awarded an increase in their dispensing fees which was dated back to Jan. 1, 1945.

#### Sickness Benefit in Pregnancy

46. In 1944 the A.R.M. expressed the opinion that ample financial provision should be made to render it unnecessary for any woman to continue in remunerative employment during the last six weeks of pregnancy. The Ministry of Health had

previously promised to issue a revised memorandum to insurance practitioners, approved societies, and insurance committees on the subject of sickness benefit in relation to pregnancy, and a draft had actually been prepared when the White Paper on Social Insurance made its appearance. The White Paper contained proposals for payment in the case of employed women of a weekly maternity benefit for a total period of thirteen weeks covering both sides of the confinement, and the Ministry did not consider it desirable to make any modification of the existing National Health Insurance scheme which might embarrass the working out of the proposals in the proposed social insurance scheme.

The Ministry is being asked to arrange that in cases where sickness benefit is paid for incapacity for work due to pregnancy the attending doctor is not required to give more than one certificate to cover the whole period.

#### **Fees for Part-time Regional Medical Officers**

47. With effect from March 1 the Ministry of Health has increased the fee payable to doctors employed as part-time regional medical officers in the examination of cases of doubtful incapacity for work from two guineas to two and a half guineas for a session of two hours. The Association's request was for an increase of the fee to three guineas.

#### **Regional Medical Service—Reference of Patients to Specialists**

48. Exchanges have taken place with the Ministry of Health on the attitude of the Ministry in cases where an insured person is referred to a divisional medical officer for an independent medical examination, and a tuberculous condition is diagnosed. The Ministry of Health has given an assurance that in those cases where the opinion of a specialist is considered to be desirable for reasons other than to enable the examining medical officer to report whether or not the insured person is incapable of work, no steps will be taken for the specialist examination without consulting the insured person's own doctor. This was satisfactory up to a point, but it was felt that it would be in the interest of the patient, the N.H.I. medical service, and the maintenance of a high standard in the settlement of cases of doubtful incapacity for work if, in the first instance, the patient's own doctor was given an opportunity of arranging for a second opinion. The Ministry does not consider it practicable or desirable to adopt this suggestion, being of opinion that by keeping the patient's own doctor informed of arrangements for a specialist examination the interests of patient and doctor are adequately met.

#### **Protection of Practices: Adjustment of Lists**

49. At the request of the Annual Conference of Local Medical and Panel Committees, consideration has been given to the practicability of making provision, on a national basis, for returning insurance practitioners to receive for a limited period payment out of the Local Practitioners' Fund of not less than they were receiving in 1939. The intention was that the practitioner should have the benefit of this payment for six quarters following his return to his practice, unless he had succeeded in building up his practice to the 1939 level earlier, when the arrangement would cease to apply to him. A national scheme of this nature, involving the creation of a central pool, would be administratively possible only if a very high percentage of Panel Committees throughout the country were willing to co-operate, and could give the necessary assurance that their constituents were in favour of the scheme. An inquiry has revealed that in a substantial proportion of areas the Panel Committees are not in favour of dealing with the problem on a national basis, preferring that it should be left to each area to make its own arrangements if it considers that any action at all is desirable. It is understood that, provided it can be shown that there is no substantial opposition from insurance practitioners in a particular area, the Ministry of Health would be willing to sanction appropriate amendments of the local Allocation and Distribution Schemes.

### **SPECIAL PRACTICE**

#### **Status of Consultants and Specialists Group Committee**

50. The Council has considered the relation of the Consultants and Specialists Group Committee to the Special Practice Committee, the other group committees, and the Council. It

thinks that the Consultants and Specialists Group Committee, representing as it does all consultants and specialists exclusively engaged as such and not merely, like the other group committees, a particular variety of consultant or specialist practice, should differ from the other group committees in being allowed direct access to the Council instead of being required to report through the Special Practice Committee. It recognizes that the existing regulations provide for recommendations of the Group Committee, even if not approved by the Special Practice Committee, being submitted to the Council with the comments of the latter committee, and for representatives of the Group Committee to be invited to attend the Council when such recommendations are discussed. It feels, however, that the exceptional position of the Consultants and Specialists Group Committee justifies the claim that it should be regarded as the principal mouthpiece of consultant opinion within the Association, and that the piecemeal development of the group system has led, more by accident than by design, to the committee occupying a position which is inappropriate and should be rectified.

The Council realizes that the continued existence of the other group committees is necessary for the detailed consideration of matters specially affecting their individual interests, and that there must continue to be a single committee in which recommendations of particular groups can be submitted to the test of wider consultant opinion. It thinks, however, that the latter function would most appropriately be exercised by a Standing Committee having, as regards a majority of its members, the composition of the Consultants and Specialists Group Committee, though it would be necessary to include also the various elements which make up the Special Practice Committee. The Council also considers that any such reconstituted committee should include representatives of members of the Association who are engaged part-time in consultant and specialist practice, and that steps should be taken to establish a list of part-time consultants and specialists for use as an electoral roll for this purpose, admission to the roll to be by application, including a signed declaration that the applicant is engaged part-time in consultant or specialist practice.

The necessary amendments of the By-laws to give effect to these proposals are submitted in another section of this report under "Organization." (See paragraph 92.)

#### **Part-time Consultants and Specialists**

51. The Council has considered the following resolutions of the A.R.M., December, 1944:

"282. That, with reference to paragraph 32, this A.R.M., whilst thanking Council for its assurance that all necessary steps are being and will continue to be taken to watch the interests of part-time consultants and specialists, requests Council to reconsider its decision on the formation of a special group";

"285. That the fact that a medical practitioner engages in general practice shall not preclude him from admission to the Consultants and Specialists List, provided that he satisfies the requirements of the British Medical Association in other respects";

and the following resolution of the A.R.M., July, 1945:

"71. That this A.R.M. requests Council to inform part-time consultants and specialists on hospital staffs what steps are being taken to safeguard their position and future employment."

Paragraph 32 referred to in Minute 282 above reads as follows:

"32. The Council has considered a suggestion made at the A.R.M., 1943, that steps should be taken, by the formation of a group or other means, to watch the interests of part-time consultants and specialists. In the opinion of the Council no action is necessary in this matter inasmuch as all necessary steps are being taken to watch the interests of part-time consultants and specialists; the formation of a special group for this purpose is undesirable."

The Council is still of the opinion that a special group of part-time consultants and specialists is undesirable. As regards A.R.M. Minute 285, if the proposal in paragraph 92 is approved the list of members of the Consultants and Specialists Group will become merely an electoral roll for the purpose of electing 20 members of the new Consultants and Specialists Committee. The Council considers it essential that a Standing Committee dealing with matters affecting consultants and specialists should have a majority of members engaged exclusively in consultant or specialist practice and elected solely by their colleagues who are so engaged. It is therefore opposed to

the admission of both whole-time and part-time consultants to a single list. It thinks, however, that the suggested establishment of a separate electoral roll to enable part-time consultants and specialists to elect 5 of their number to the proposed new Standing Committee should satisfactorily meet the demands of this section of the Association's membership by ensuring discussion of any matters specially affecting its interests. The Council believes that these interests will best be safeguarded through direct representation of part-time consultants and specialists on the proposed Consultants and Specialists Committee.

#### Consultants and Specialists and a National Health Service

52. The Council has considered, in relation to consultant and specialist practice, Minute 98 of the A.R.M., 1945:

"98. Resolved: That the Council be requested to give concrete proposals safeguarding private practice under a 100% National Health Service."

The Council thinks that what is of chief importance in this connexion is to maintain the right of consultants and specialists to charge fees for their professional services to patients who elect to enter private wards. It has submitted the following recommendation for consideration by the Negotiating Committee:

"That patients entering paying wards, blocks, or wings should be allowed to retain benefit in these circumstances, but it should be regarded in the nature of a 'grant-in-aid' and they should pay for their maintenance and treatment privately."

The following are other proposed safeguards for consultants and specialists which the Negotiating Committee has been asked to consider:

- i. The traditional relation between the consultant and the family doctor should be preserved.
- ii. The reference of a patient to hospital should be on the recommendation of a general practitioner, who should supply a clinical history of the case.
- iii. Consultants should be available under the scheme for domiciliary work only within the district they serve.
- iv. There should be freedom of choice of consultant within prescribed limits.
- v. The consultant should be safeguarded from having to perform duties normally undertaken by a general practitioner.
- vi. There should be recognized hours on and off duty for whole-time consultants and recognized hours of duty and hours of availability for consultation for part-time consultants.
- vii. There should be agreed holidays and time for study and research as part of the contracted time in the service both for whole-time and part-time consultants.
- viii. Arrangements should be made for appeal by consultants having proposals or grievances concerning the service.
- ix. Domiciliary visits under the scheme should only be undertaken when the patient is unable to attend hospital, and should take place in the presence of the general practitioner.

#### Examination of Pensioners referred to Specialists

53. The Council has approved a revised scale of fees offered by the Ministry of Pensions for cases referred to specialists, under which the specialist receives a fee of £2 2s. for a single case, £2 15s. for two cases, and £3 5s. for more than two cases. These fees, which are in accord with the Ministry of Labour scale, are payable when the number of cases is insufficient to occupy a specialist for a full session, or when the examination is carried out at the specialist's own residence.

In 1941 a separate scale of fees was agreed between the Association and the Ministry of Pensions for radiological reports, the fees to be the same whether the work was carried out at the hospital or privately in the radiologist's rooms and to be inclusive of the cost of material, etc. The scale was divided into four sections, the fees being £1 1s., £1 11s. 6d., £2 2s., and £3 3s. according to the nature of the examination. The Council considers that these fees are inadequate, and in order that the scale may be brought into line with that approved by the Ministry of Labour and National Service the Ministry of Pensions has been asked to approve £3 3s. as the fee for radiological reports in all types of examination included in the present scale, except such special examinations as tomography, myelography, ventriculography, encephalography, urography,

barium meals, and enemas and similar elaborate techniques, in respect of which the appropriate fee should be £5 5s.

#### Psychiatry and the Law

54. In 1939 a conference between representatives of the Psychological Medicine Group Committee of the Association and the Magistrates' Association was held to consider matters of common interest to psychiatrists and magistrates, and a proposal was made for a joint committee to continue the discussions. The formation of a committee, however, was prevented by the outbreak of war. Further discussions have recently taken place, and these have resulted in the formation of a permanent joint liaison Committee on Psychiatry and the Law to provide a channel for co-operation between the Association and the Magistrates' Association. The joint committee will consider all matters of common interest with special reference to observation, prevention, and treatment in relation to the medical aspects of legal offence, and will make recommendations for the improvement and extension of existing arrangements and for facilitating new legislation. A note of the work of the joint committee will be found in paragraph 10.

#### Pensions Appeal Tribunal Rules

55. The Council has considered the following Minute 286 of the A.R.M., December, 1944, with the result that representations have been made for the amendment of the rules in the manner set forth in the resolution:

"286. Proposed by Hendon (Robert Forbes): That the Council be requested to take early steps to seek the amendment of the Pensions Appeal Tribunals (England and Wales) Rules, 1943, in the following respects, viz:

(a) That the term 'Medical Specialist' be inserted and defined in Rule 1 of the Interpretation Clause as meaning a 'registered medical practitioner possessing professional and academic attainments warranting his recognition by the medical profession as a consultant.'

(b) That Rule 16 be varied to preclude the examination of an appellant by the medical member of the Tribunal.

(c) That under the authority of Rule 27 the fee payable to a 'Medical Specialist' for an examination and report upon the condition of an appellant shall be not less than five guineas, with discretion vested in the President of the Tribunal to direct the payment of a larger fee in cases of exceptional difficulty.

(d) That Part II of the Second Schedule to the Rules be varied to provide for the payment of a fee of not less than three guineas for the attendance of a medical witness before the Tribunal and the payment of two guineas for an examination and written report upon the appellant's condition.

Resolved: That this matter be referred to the Council for consideration."

#### Occupational Therapy and Mental Nursing

56. In the absence of any recognition of occupational therapy in the Report of the Mental Nurses Subcommittee of the Rushcliffe Committee, and in view of confusion which had arisen concerning the payment of nurses, both male and female, employed in mental hospitals and mental deficiency institutions and spending a considerable part of their time in occupational therapy, the Royal Medico-Psychological Association passed a resolution, which was transmitted to the Ministry of Health, expressing the opinion that occupational therapy when carried out by a mental nurse is a nursing duty, and should be recognized as such. The Council has sent a communication to the Ministry of Health supporting this view.

#### Access to Ancillary Departments of Hospitals

57. The Council has considered a proposal that access to all ancillary departments of a hospital (diagnostic and therapeutic) should be via members of the medical and surgical consulting staff. In support of this proposal it has been suggested that the policy of the "open door" is liable to result in the departments of pathology and radiology being flooded by cases referred unnecessarily, and that it would be of value in connexion with the teaching of students if all patients referred to hospital for pathological or radiological investigation passed through the out-patient departments. The Council is of the opinion that the "open door" policy should be put to the test of experience in order that its advantages and disadvantages may be ascertained.

## PUBLIC HEALTH

## Salaries in the Public Health Service

58. The Council has noted for action at the appropriate time the following resolution of the A.R.M., 1945:

"119. Resolved: That negotiations with regard to salaries and conditions for doctors in the public health and municipal hospital services be conducted with the Government as part of the negotiations for the whole profession and not as on previous occasions with the Association of Municipal Corporations and County Councils."

59. Draft revised scales of remuneration are being discussed with various interested bodies, but before their final form for purposes of negotiation is decided on it is considered advisable to take into account the report of the Spens Committee on the remuneration of general practitioners, which is expected shortly.

60. As there will undoubtedly be a considerable interval between the termination on March 31, 1946, of the Askwith Agreement and the settlement by negotiation of the new scales, the Council has endeavoured to secure an interim percentage increase in remuneration. It put forward the following proposals at a conference with representatives of the Ministry of Health, local authority associations, and the L.C.C.:

(1) Subject to any necessary marginal adjustments (a) all existing salaries not exceeding £1,000 to be increased by an annual sum equivalent to 30% of the minima of the respective scales laid down in the Askwith Agreement, or where the Askwith Agreement is inapplicable—e.g., in the case of appointments at mental hospitals—30% of the minima of the scales appropriate to the appointments in 1939; and (b) all existing salaries exceeding £1,000 to be increased by 20% of the minima of the respective Askwith scales or 1939 scales as the case may be.

(2) New appointments to be advertised at salary scales 30% higher throughout than the respective scales laid down by the Askwith Agreement or where that Agreement does not apply—e.g., appointments at mental hospitals—30% higher than the appropriate 1939 scales up to £1,000 per annum basic, after which the increase should be 20% in both cases, marginal adjustments being made where necessary as in (1) above.

61. The Council was not successful in securing complete acceptance of its proposals, but the conference agreed to the submission of the following formula to the local authority associations and the L.C.C.:

(1) The recommendations in the Askwith memorandum shall continue as an interim measure with the following adjustments until new scales come into operation:

(a) Incremental scales—i.e., the rates of pay quoted in the memorandum for resident medical officers, medical officers employed in departments, senior medical officers, medical superintendents of institutions other than mental hospitals, and assistant medical officers to mental hospitals—shall be increased throughout the scale as follows: (i) if the minimum of the scale does not exceed £700, by 30% of that minimum; (ii) if the minimum of the scale exceeds £700 but does not exceed £1,000, by 20% of that minimum; (iii) if the minimum of the scale exceeds £1,000, by 10% of that minimum.

The rate of pay of £1,100 quoted in the memorandum as the rate not to be exceeded for senior medical officers or medical superintendents of institutions other than mental hospitals (Sections III (4) and IV (4) of the memorandum) shall be increased by 10%.

(b) The minimum commencing salary of other rates of pay—i.e., for deputy or chief assistant medical officers of health, for medical officers of health, and for combined posts—shall be increased: (i) if it does not exceed £700, by 30%; (ii) if it exceeds £700 but does not exceed £1,000, by 20%; (iii) if it exceeds £1,000, by 10%.

(2) The foregoing arrangements, which are without prejudice to any subsequent negotiations upon a permanent substitute for the Askwith Agreement and are in addition to any existing war bonus, are to have effect as from April 1, 1946.

(3) Medical officers already serving in posts covered by the Askwith memorandum on April 1, 1946: (a) if they are in a post to which paragraph (1) (a) above applies, and if they are receiving not more than the maximum of the present scale, shall be given from that date an increase of pay equal to the appropriate percentage of the minimum of the present scale indicated in paragraph 1 (a) (i), (ii), or (iii), as the case may be; and if they are receiving a rate of pay in excess of that maximum but less than the maximum of the revised scale shall be given an increase of pay which will bring them to the revised maximum. (b) If they are in a post to which paragraph (1) (b) above applies, and if their salary does not exceed the appropriate minimum embodied in the memorandum plus 20%, shall from that date have their salary increased by the appropriate percentage of the minimum indicated in paragraph (1) (b) (i), (ii), or (iii), as the case may be.

(4) In respect of all categories, marginal adjustments shall be made to ensure that an officer shall not receive, as a result of the new arrangements, either less than an officer in a post to which at present a lower rate of pay applies, or less than he would have received had his rate of pay been lower than that which he at present receives.

(5) Local authorities will appreciate that application of the above arrangements will not automatically entail an increase in the salary of all public health medical officers, some of whom are not covered by the Askwith memorandum. In cases where present salaries are such as to disqualify their recipients, either in whole or in part, from receipt of the salary increases now agreed, local authorities clearly have discretion, in some cases with the consent of the Minister of Health, to review existing rates of remuneration.

62. The Council has approved the foregoing proposals; if and when they are also approved by the local authority associations and the L.C.C., the Ministry of Health will commend them to local authorities for adoption. When the form of the proposals is finally settled, steps will be taken with a view to their application to holders of appointments under Scottish local authorities.

The revised proposals do not apply to medical officers whose posts are not covered by the Askwith Agreement—e.g., mental hospital medical superintendents and their deputies, and certain categories of municipal specialists—and the appropriate bodies are being urged to consider the position of such officers.

## Cost-of-living Bonus

63. The Council has considered the following resolution of A.R.M., 1945:

"Resolved: That (1) this A.R.M. reaffirms the policy that men and women medical practitioners shall receive equal pay for equal work; (2) it shall be understood that this policy shall include cost-of-living bonus; (3) where authorities or other bodies have not paid the same cost-of-living bonus to women as to men they should take immediate steps to rectify the position, and such rectification should be retrospective."

The question of securing the application of the principle of equality of remuneration to cost-of-living bonus has been investigated, but difficulties have been encountered. In the first place Government Departments do not approve for grant or reimbursement purposes any expenditure by local authorities on bonus which exceeds the rates recommended in the Civil Service scale or the scale of the National Joint Council for Local Authorities' Administrative, Professional, Technical, and Clerical Services, both of which differentiate between men and women; local authorities themselves would therefore be debarred from taking any action. In the second place the whole question of equality is *sub judice* in the Royal Commission, and the National Joint Council, whose scale most local authorities have adopted, found itself unable to recommend an alteration of practice which would have to apply not only to doctors but to all other employees of local authorities. In view of this position it was decided in November, 1945, to leave the matter in abeyance and to request the Negotiating Committee to secure the implementation of the Association's policy in the new scales. Early in 1946 the matter came before the Council again when the Treasury decided to effect a consolidation of the cost-of-living bonus with salary in the case of the Civil Service. The Council immediately sent a deputation to the Ministry of Health, and the Ministry gave an assurance that the recent consolidation, which maintained the differentiation between the sexes, was temporary only, and that new consolidated scales were being prepared which would be the same for men and women doctors.

Local authorities, including the London County Council, are not yet contemplating consolidation, but it has been suggested to them, through the local authority associations, that pending the formulation of interim arrangements regarding public health medical officers' remuneration on the termination of the Askwith Agreement, nothing should be done by consolidation or otherwise which involves a departure from the principle of equality for men and women medical officers.

## Pensionable Age

64. The Council has referred to the Negotiating Committee the following resolution of the A.R.M., 1945:

"134. Resolved: That the pensionable age of medical women should be the same as that for medical men."

**Bonus for Pensioners**

65. The Council has considered the following resolution of the A.R.M., 1945:

"135. Resolved: That the Council be instructed to approach the appropriate authorities—e.g., the local authorities and Government Departments—to ask that the cost-of-living bonus be given to pensioners formerly employed by them."

The appropriate Government Departments have been asked to consider granting this request to pensioners formerly employed in the Civil Service, and giving to local authorities any necessary powers to enable them to do so in the case of local authority pensioners.

**National Maternity Service**

66. The Council has considered the following resolutions of the A.R.M., 1945:

"125. Resolved: That, with reference to paragraph 32 of the Annual Report of Council, those practitioners who have had extensive and lengthy practical experience in midwifery should *ipso facto* be eligible to sit for the Diploma in Obstetrics and Gynaecology without the necessity of having held a resident post in midwifery, and that this suggestion be brought to the notice of the College."

"127. Resolved: That, with reference to paragraph 32 of the Annual Report of Council, this Representative Body is determined to pledge itself to resist the introduction of any new criteria of qualification in midwifery that would, if officially recognized, deprive any registered medical practitioner of the right to practise midwifery in a national service."

"130. Resolved: That all ante-natal examinations should so far as possible be carried out by the doctor who is eventually responsible at the confinement."

"131. Proposed by Bradford (G. Priestman): That this meeting approves generally the principle instituted by and policy pursued according to the Report of Council, 1945, and is particularly emphatic in agreeing with paragraph 32. It also draws attention to and deplors the views expressed in the Nuffield Hospital Report for Yorkshire on page 90 where 'continuous compulsory supervision of children' by a small group of medical men is advocated, and on page 95 where the removal of mothers and children from family general practitioner attendance is advocated, and draws the attention of Council thereto."

"Resolved: That this motion be referred to the Council."

Meetings were held with the Royal College of Obstetricians and Gynaecologists for the discussion of those parts of the report of the College, referred to in the Annual Report to the A.R.M., 1945, which were in conflict with the policy of the Association—notably the proviso that the general practitioner who desires to undertake midwifery must have special experience if he wishes to take part in the service in domiciliary midwifery, at an ante-natal clinic, or in advising during the post-natal period. Provisional agreement was at first reached on the following statement:

"(1) After qualification a practitioner needs adequate and regular experience in obstetrics to be a good obstetrician. (2) Midwifery standards should be raised by (a) the inclusion of a resident midwifery post in the pre-registration compulsory hospital posts as proposed by the Goodenough Committee; (b) creating an increased number of resident obstetric hospital posts available to recently registered practitioners; (c) the organization of the proposed comprehensive medical service so as to secure for each pregnant woman a general practitioner, a midwife and, where necessary, an obstetric specialist; (d) the recognition for the purposes of the future service of those general practitioners who desire to undertake obstetrics, provided that they undertake sufficient midwifery to enable them to remain efficient."

On reconsideration, however, the College reaffirmed the principles in its report on "A National Maternity Service," published in May, 1944, and stated as follows:

"The Council is of the opinion that a pre-registration resident appointment of four months, of the type propounded in the Goodenough report, would be insufficient for the purpose, and would not fulfil the condition laid down on page 33 of the College's report: 'Secondly, those who after qualification have held a resident obstetric appointment in an approved hospital'; nor the condition laid down on page 4: 'We believe that the qualification for general practitioners to work in a national maternity service should be special and approved postgraduate experience.' The Council amended your four proposals as follows, and passed a resolution accordingly:

"That midwifery standards should be raised (a) by ensuring that general practitioners who are employed in a national maternity service have had special experience either (i) on account of having had a large midwifery practice over a number of years and having become skilful and experienced in this way, (ii) having held a post-registration resident appointment in obstetrics in an approved hospital; (b) by creating an increased number of resident obstetric hospital posts available to recently registered practitioners; (c) by the organization of a National Maternity Service so as to make available for each pregnant woman a midwife, a general practitioner with special experience, and an obstetric consultant."

In spite of further discussions the College adheres to its original views.

**Doctors employed Part-time by Local Authorities**

67. The Council has prepared a revised scale of fees for doctors employed part-time by local authorities.

**Recommendation:** That, in substitution for the existing scales, the scales set out below be adopted for the remuneration by local authorities of medical practitioners employed by them on a part-time basis:

**A. Remuneration on a Sessional Basis****(1) Consultants and Specialists**

For all regular consultant and specialist sessions, of not more than 2 hours' duration, at hospitals and clinics, including (a) administration of anaesthetics, (b) treatment of venereal diseases, (c) x-ray examination and treatment, including ringworm, (d) adenoid and tonsil operations, (e) examination and certification of blind school-children, (f) ophthalmic work for school-children:

Regular weekly sessions: £273 per annum per weekly session—i.e., at a rate of £5 5s. per session.

Individual, occasional, or additional sessions and emergency attendances: £5 5s. per session or attendance.

These rates are intended for application to all persons possessing the necessary qualifications and experience, and it is recognized that higher remuneration should be paid where senior consultants are required for work carrying special responsibilities.

**Mileage.**—An additional allowance of 1s. per mile each way should be paid as compensation for time spent in, and cost of, travelling.

**(2) General Practitioners**

For sessions of not more than 2 hours' duration:

Regular weekly sessions: £163 16s. per annum per weekly session—i.e., at a rate of £3 3s. per session.

Individual, occasional, or additional sessions and emergency attendances: £3 3s. per session or attendance.

For sessions of one hour: £2 2s. per session.

**(3) Duration of Sessions**

Where sessions tend regularly to exceed two hours the position should be regularized by an appropriate increase in the number of sessions per week for which remuneration is paid.

**(4) Annual Leave**

Where payment is by annual salary, six weeks' annual leave, with pay, should be allowed.

**B. Remuneration on a Payment-per-case Basis****CONSULTANTS AND SPECIALISTS****(5) Surgical Operations**

The fee payable to a surgeon called in to operate in an emergency, including emergency domiciliary obstetrical operations, should be related to the services rendered, and should not in any case be less than £10 10s. plus mileage at the rate of 1s. per mile each way.

**(6) Domiciliary Consultations**

The fee payable for a consultation at the home of a patient should be £5 5s. plus mileage at the rate of 1s. per mile each way.

**(7) X-ray Treatment of Ringworm**

Where the local authority refers cases to the radiologist at his private clinic: £5 5s. per case.

**(8) Blind Persons Act**

Where sessional arrangements are impracticable: For medical certificates of blindness for any one of the following purposes where B.D.8 or any other recognized form of report is required, not less than £2 2s.: (a) to support a claim for a pension under the Blind Persons Act, 1920; or (b) to support an application in respect of a blind person by a local authority or voluntary agency for grant

out of public funds under the regulations for the welfare of the blind, or under the Education Committee; or (c) to obtain evidence of blindness before the registration of a blind person.

Where the ophthalmic surgeon is required to visit the patient:

- (i) within two miles of the ophthalmic surgeon's consulting room—not less than £3 3s.;
- (ii) beyond two miles—not less than £4 4s. plus mileage both ways at the rate of 1s. per mile.

#### GENERAL PRACTITIONERS

##### (9) *Ante-natal and Post-natal Examination*

- (i) 7s. 6d. for each ante-natal or post-natal examination;
- (ii) 12s. 6d. per case for examination and report to the local authority if requested by the local authority.

##### (10) *Diphtheria Immunization*

- (i) The material should be supplied without cost by the local authority.
- (ii) Fee for immunization at a doctor's surgery: 3s. 6d. per injection.
- (iii) Fee for visiting a child at home and giving injections there: 6s. a visit plus mileage.
- (iv) For injecting children at a centre there should be paid a fee of £3 3s. for 2 hours, together with mileage, the time being measured from arrival at the centre to departure from it.

##### (11) *Other Services*

For services not mentioned above both in respect of consultants and specialists and general practitioners the rate of remuneration should be arranged after consultation between the local authority and the local Division of the Association.

The question of remuneration for the administration of general anaesthetics by general practitioners for local authority cases is still under consideration.

The Negotiating Committee has been asked to consider the revised part-time scales in conjunction with scales of remuneration for whole-time public health medical officers.

#### Vaccination Fees

68. The Council has considered the following resolution of the A.R.M., 1945:

"124. Resolved: (1) That this meeting considers that the fees paid to public vaccinators are still totally inadequate and that the Council be asked to press for uniformity throughout the country. (2) That the scale of fees paid should be the same as has been formulated for the West Riding administrative area of Yorkshire, which has been accepted by the Yorkshire Branch Council of the B.M.A. and approved by the Ministry of Health (see *British Medical Journal Supplement*, May 19, 1945, p. 94) with the addition: (a) that such fees should be paid whether vaccination is successful or unsuccessful, and (b) that a mileage charge of 2s. (two shillings) a mile per vaccination over two miles to be paid."

Representations have been made to the Ministry of Health on the lines of the resolution, but the Ministry has stated that it is unable so soon after the issue of the Vaccination Regulations, dated Dec. 1, 1944, to make further regulations involving another revision and embodying a new provision in the sense indicated in (2) (a) above, and, further, that it does not feel justified in imposing uniformity of fees on authorities. The Council has not pressed the matter in view of the probable repeal of the Vaccination Acts in the near future. It has, however, continued to make representations with regard to the payment of awards to public vaccinators. The Ministry states that it was not possible during the exigencies of war to maintain the routine examination of records on which awards depend, and it proposes to defer action until a final settlement can be made on the termination of the present vaccination system. As, however, some public vaccinators have not received any payments since dates considerably before the war, the Ministry has been urged to resume the procedure as soon as possible.

#### County Medical Officer of Health Appointments

69. The Council has requested the Ministry of Health to consider making regulations requiring county councils to advertise county medical officer appointments. Legislation already exists which requires the advertisement of appointments of medical officers of health of boroughs and urban and rural districts.

#### Milk

70. The Council, on the instructions of the A.R.M., 1945, has made representations to the Ministry of Health that legislation be introduced requiring milk sold for human consumption to be pasteurized. The Ministry has referred to the high proportion of milk which is now either heat-treated or tuberculin-tested, but the Council has made further representations that, notwithstanding any steps taken to secure tubercle-free herds, legislation should require pasteurization as distinct from heat-treatment, as the repeated application of the latter process involves a loss in the food value of milk.

#### Chronic Sick

71. The Council has considered the following resolution of the A.R.M., 1945:

"117. Resolved: That the Minister be asked to request local authorities or like bodies to implement their statutory responsibility for the care of chronic sick at the earliest possible moment."

It has been conveyed to the Ministry of Health and the Ministry of Labour with observations on the inadequacy of institutional accommodation and the more acute problem of staff shortage, and with a recommendation urging the acceleration of the demobilization of nurses and the transfer of nursing and domestic personnel from industrial employment, with a view to easing the situation. The publication early in 1946 of the Assistant Nurse Rules, 1945, including a syllabus of training for assistant nurses, should stimulate local authorities to seek approval of their public assistance institutions as assistant nurse training schools, and it is hoped that this will contribute further to a solution of the staffing problem. (See also paragraph 21.)

72. One of the provisions of the Assistant Nurse Rules is the admission to the Roll of Assistant Nurses of those assistant nurses who have had not less than two years' training or experience by Jan. 1, 1948. By reason of the late publication of the Rules it will not be possible for persons entering the nursing profession subsequent to publication to gain admission to the Roll by fulfilling this requirement, and representations have been made to the Ministry of Health with a view to an amendment of the date to Jan. 1, 1949. The Ministry has replied that this matter is under active consideration.

#### School Medical Reports

73. The Council has deferred consideration of the following resolution referred to it by the A.R.M., 1945, until details of the National Health Service are available:

"113. Proposed by Derby (E. C. Dawson): That school medical reports shall be made available only to the patients' own doctors. Other medical officers requiring school medical reports should first obtain the written consent of the parents or guardians."

#### Mass Radiography

74. The Council's advice has been sought by a Division on the procedure which should be followed for imparting to a person's medical attendant the radiological findings of mass radiography units. It has advised that the information should be given when the findings are complete, whether after the first examination by the unit or after a further radiological examination when this is found necessary.

The Minister of Health has been asked to arrange that in all cases where persons are examined by mass miniature radiography the findings—positive or negative—will be communicated to the person's own doctor.

#### EDUCATION ACT

75. The Council has considered the following resolutions of the Annual Representative Meeting, 1945:

"Mins. 109 and 110. Resolved: That the A.R.M., having considered the Report of Council on the 1944 Education Act, stresses the following observations. It upholds the principle that the health of the child should be in the care of the family doctor, and it should be his responsibility to obtain any necessary consultant services, and that the Council be instructed to arrange for adequate representation of the views of consultants (whole-time and part-time) including a special meeting in London of representatives of consultants."

"Min. 114. Resolved: That, with reference to paragraphs 25 and 26 of the Annual Report of Council, the Representative Body places.

on record its grave dissatisfaction with the failure of the late Minister of Education to receive favourably the proposals of the Council of the Association on the inability of the profession to implement at present and for some time to come the operation of Section 48 (3) of the Education Act, 1944, and urges the Council to warn the new Government of the need to suspend the operation of this section until agreement has been reached on the terms and conditions applicable to the establishment of a National Health Service."

Section 48 (3) of the Education Act requires every local education authority "to make such arrangements for securing the provision of free medical treatment for pupils in attendance at any school or county college maintained by them as are necessary for securing that comprehensive facilities for free medical treatment are available to them either under this Act or otherwise. . . ."

In connexion with the development of medical services for the purpose of the Act the Council is of the opinion that agreement should be reached on a national basis for the remuneration of medical personnel whose services are utilized, and that the Ministry should secure acceptance of such nationally agreed arrangements before giving approval to local schemes. With this object in view, and without prejudice to negotiations in connexion with the National Health Service, the Council submitted to the Ministry of Education proposals on the following lines:

#### *Hospital Services*

(a) Where there are long-established agreements between education authorities, voluntary hospitals and their medical staffs—as, for example, in respect of ear-nose-and-throat and ophthalmic work—such agreements should be left undisturbed, provided the remuneration is in accordance with the Association's scale for doctors employed on a part-time basis by local authorities, as increased by the 20% recommended by the Association.

(b) The payment of medical staffs of voluntary hospitals in respect of general medical and surgical work should be related directly to the professional services rendered, rather than to maintenance rates, which fluctuate in hospitals of different size.

(c) In respect of in-patients, payments should be at a rate of not less than 1½ guineas per week.

(d) In respect of out-patient consultations or treatment, the fee should be 10s. 6d. per new case to include attendance up to three months from the date of the first attendance.

(e) Where circumstances permit of the arrangement of clinics for school-children exclusively, remuneration should be on a sessional basis and not less than the minimum fee approved by the Association for part-time local authority sessional work generally.

(f) Payments should be allocated to the medical staff fund of the hospital, distribution among individual members of the staff being determined by the medical staff committee on the basis of work done or responsibility borne.

#### *General Practitioner Services*

(a) The reference of patients to the practitioner should ordinarily be through the parent or guardian provided the school medical officer should not be precluded from referring children found needing medical care at the routine inspections to a medical practitioner at hospital, clinic, or surgery. The local education authority should accept responsibility for payment of the practitioner's fee.

(b) The fee for attendance at the doctor's surgery should be not less than 5s. including medicine; the existing practice for payment for emergency attendance at schools should be preserved where this is satisfactory.

The Ministry accepted the principle of payment being made for services rendered by doctors in voluntary hospitals, and expressed its willingness to include in a circular to local education authorities the following recommendations:

#### *Out-patient Treatment*

1. Where the authority enters into contractual arrangements with consulting physicians or surgeons, payment should normally be made on a sessional basis at a fee not exceeding 3 guineas per session of two hours. Where sessional arrangements cannot be made, the Minister would approve payments not exceeding 12s. 6d. per case. The above provisions apply to sessions held or treatment given either in school clinics or in hospitals.

2. Where there are no contractual arrangements between the authority and the consultant, and where children for whom the authority accepts responsibility attend clinics held at voluntary hospitals, the Minister will approve payments to the hospitals in respect of the services of the visiting medical staffs at the rate of 10s. 6d. for each new case, this sum to cover attendances up to three months and any consultations and treatment given in that

period. This payment will be made to the hospital for distribution among the visiting medical staff.

#### *In-patient Treatment*

3. In the case of operative treatment for enlarged tonsils and adenoids, it has been the normal practice for local education authorities to pay fees in respect of the services of the surgeon and the anaesthetist, and the Minister will be prepared to recognize for grant such payments at a rate not exceeding £1 17s. 6d. per case, or 6 guineas per session of not more than eight cases.

4. In the case of all other forms of in-patient treatment for which authorities accept responsibility, the Minister will be prepared to recognize the payment to the hospital for distribution among the visiting medical staff of 21s. per child to cover any period up to 14 days, and thereafter at the rate of 1s. 6d. a night. In order to obviate any duplication, this sum will be subject to a token reduction of 2s. 6d. per week, or 3d. per night, in cases where the hospital is making payments out of its own funds to one or more of its visiting medical staff.

5. In announcing the decisions set out in the preceding paragraphs, the Minister wishes it to be understood: (a) that these decisions are without prejudice to any arrangements which may be introduced in connexion with the proposed National Health Service; (b) that arrangements already made by authorities with the Minister's approval for payment at rates in excess of those shown above may stand; (c) that authorities are at liberty to apply for the Minister's special approval of arrangements not clearly falling within the limits set out above; (d) that arrangements made in accordance herewith will, if authorities so desire, be approved retrospectively with effect from April 1, 1945.

The Council informed the Ministry:

(a) That subsequent to the discussions with its representatives, the Association's scales of remuneration for medical practitioners giving part-time services to local authorities had been under revision and that the Representative Body in July would have before it proposals for increasing the present scales;

(b) that the payment to the visiting medical staff of 21s. per child in-patient to cover any period up to 14 days and thereafter at the rate of 1s. 6d. a night, was inadequate; it was inappropriate that the E.M.S. rates of remuneration, which were negotiated for the unusual circumstances of the war, should be applicable during the post-war interim period;

(c) that subject to this reservation relating to in-patient treatment the Council was in general agreement with the Ministry's proposals;

(d) that in so far as the Ministry's proposals were acceptable to the Council it was on the understanding that the right was reserved to reopen discussions in the light of the modifications that might be made in the Association's scales of remuneration at the Representative Meeting in July.

After further discussions with representatives of the Association the Ministry agreed to modify paragraph 4 of its proposals, and to authorize a payment of 21s. per child to cover any period up to seven days. The Ministry would not agree to refer in its circular to education authorities to a fee for attendance at the doctor's surgery, regarding it as a matter to be settled locally in view of the small number of such cases likely to arise; but it is understood that for grant purposes the Ministry would be prepared to allow a fee not exceeding 5s. per surgery attendance.

### BRITISH MEDICAL JOURNAL

76. Throughout the whole of the war the *British Medical Journal* appeared regularly week by week notwithstanding the difficulties of production and distribution, the severe rationing of paper, and the shortage of staff.

Since last year's report under this heading the obligatory circulation of the *Journal* has continued to mount in step with the large rise in membership of the Association, and the weekly printing order is now 55,500 copies. If that figure is not exceeded it should still be possible with the present ration of paper to produce a journal having an over-all size of 68 pages, compared with an average weekly total of 144 pages in the year 1938. When more printing paper is allowed by the Government it is hoped to give up some of the drastic economies of space which were inevitable under wartime conditions, and to revive the weekly "Key to Current Medical Literature" which was dropped in September, 1939, and to restore other features. This revival of the "Key" would form part of a comprehensive abstracting service which the Council has approved in principle.

From the early months of 1942 circulation outside the membership was curtailed drastically and new subscriptions have been declined while the paper situation remains acute. The number of original articles and medical memoranda submitted for publication is far in excess of the space now available; 870 signed articles were received in the Editorial Department in 1945, and the indications are that the total for 1946 will be at least as large as before the war. The number of letters sent for publication has grown steadily and it is possible to print in the *Journal* or *Supplement* only a selection from the large volume of correspondence on the many subjects which interest members of the Association and affect the work and welfare of the profession. Throughout 1945 additional pages were allocated to the *Supplement* for the publication of matter concerning the Government's proposals for a National Health Service, and to make room for correspondence on demobilization and resettlement of medical officers serving with the Forces. In view of the keen attention paid to the *Supplement* by members, the size of type and the two-column arrangement of its pages were restored during the year.

The new feature introduced into the *Journal* early in 1943 under the heading "Any Questions?" has maintained its popularity with readers and is continued each week in response to a very widespread demand. A first selection of queries and answers was prepared many months ago for republication in book form, but authority for an allowance of printing paper for this purpose cannot even yet be obtained from the Ministry of Supply.

#### Special Quarterly Journals

77. In spite of printing difficulties and heavy pressure of work on the editors, the *Archives of Disease in Childhood* and the *Journal of Neurology, Neurosurgery, and Psychiatry* have continued to appear throughout the war, though with not quite the usual regularity, and the Association was able to add to its list of special quarterlies the *British Journal of Industrial Medicine* and the *Annals of Rheumatic Diseases*. The former periodical is published in conjunction with the Association of Industrial Medical Officers, and the latter with the Empire Rheumatism Council. On the recommendation of the Journal Committee the Council agreed in 1944 that the Association should publish a *British Journal of Social Medicine* under the editorship of Prof. F. A. E. Crew, assisted by Sir John Orr and Prof. Lancelot Hogben. The Ministry of Supply at first declined to issue a licence to publish, but with the end of the war an allowance of printing paper has been authorized for the *British Journal of Social Medicine*, and also for the *British Journal of Pharmacology and Chemotherapy* and for *Thorax*, two new quarterlies which the Association will publish in conjunction with the British Pharmacological Society and the Association for Study of Diseases of the Chest. After consultation with the British Paediatric Association and the editorial committee of the *Archives of Disease in Childhood* the British Medical Association, on the advice of the Journal Committee, has purchased the rights of the *British Journal of Children's Diseases*, which is now incorporated in the *Archives*.

### SCIENCE

#### Library

78. The Library service has been maintained without interruption during the war years in spite of acute staff difficulties, and the Council has placed on record its appreciation of the devoted service given to the Association by the librarian during this period. The average number of books borrowed during the war remained at approximately peacetime level, though there was a reduction of about 30% in the number of readers. Allied medical officers in this country were granted permission to use the library for reference, and full use was made of this concession. The Council, recognizing the importance of the Library facilities to members, has increased the grant for the purchase of books, and is arranging to improve the existing inadequate accommodation of the library. Plans have been made to build an annexe which will provide additional office and storage space, and the lighting is to be improved.

In order that the facilities of the Library may not be denied to members resident over-seas, especially to those members serving with the European Army of Occupation, the Council has decided, as an experiment, and with reasonable safeguards,

to allow these members to borrow books. If *Journal* articles are required photostat copies will be made and sent to members without charge.

#### Central Medical Library Bureau

79. The Council has accepted an invitation to be enrolled as an Associated Library of the Central Medical Library of the Royal Society of Medicine. This library has been established as a result of the gift of £60,000 to the Royal Society of Medicine by the Rockefeller Foundation, and its objects are to assist in the rehabilitation of medical libraries which have suffered devastation or deprivation during the war, and to provide associated libraries with microfilm copies of journals which they need and cannot obtain in print. The service will be continued until such journals are available through normal methods, priority being given to associated libraries in liberated Europe. Each associated library will be provided with an appropriate reading apparatus.

#### Films in Medical Education

80. The Council has considered the question of the use of films for purposes of medical education. At the present time there is no effective co-ordination in this field and the Council believes that, as films will undoubtedly play a considerable part in medical education in the future, the Association could do valuable work by ascertaining the type of films best suited for purposes of medical education, what films are available at present, and how they can best be utilized in the interests of the profession. The Council has accordingly appointed a special committee to inquire into the scope and use of films for postgraduate and undergraduate medical education.

#### Association Prizes

##### Sir Charles Hastings Clinical Prize

81. The Sir Charles Hastings Clinical Prize, consisting of a certificate and cheque for 50 guineas for the promotion of systematic observation, research, and record in general practice will be awarded in 1946.

##### Katharine Bishop Harman Prize

The Katharine Bishop Harman Prize, which has for its purpose the encouragement of study and research into the disorders incident to maternity, will be awarded in 1946. The prize will consist of a certificate and cheque for £75.

##### Middlemore Prize

The Council has decided on the following subject for competition for award of the Middlemore Prize: The aetiology and treatment of chronic iridocyclitis. The prize consists of a certificate and a cheque for £50.

##### Stewart Prize

In view of the fact that the Stewart Prize for research into the origin and spread of epidemic disease has not been awarded since 1938 the Council has decided to award two prizes in 1946. The prizes have been awarded to Prof. Major Greenwood, F.R.S., F.R.C.P., of Loughton, Essex, and Dr. W. N. Pickles, of Aysgarth, Yorkshire. Each prize consists of a certificate and a cheque for £50.

#### Research Scholarships

82. The Council has resumed the award of the Association's scholarships. For the year 1946 it has decided to award six scholarships, instead of the usual five, but to make no grants. The six scholarships have been awarded as follows:

##### Ernest Hart Memorial Scholarship (£200)

Stockings, G. R. (Oxford),  
M.B., B.S., D.P.M.

Research on psychiatric treatment, with special reference to a new form of pharmacological therapy for the chronic type of depressive conditions—i.e., anxiety states and neurotic depressive conditions.

##### Walter Dixon Memorial Scholarship (£200)

Spillane, J. D. (London),  
M.D., M.R.C.P.

Research on nutritional neuropathy in repatriated British prisoners of war from the Far East.

*Ordinary Research Scholarships (£150 each)*

- Anderson, M. (Gateshead), M.D., M.R.C.P. An inquiry into the aetiology, pathogenesis, symptomatology, diagnosis, and treatment of peptic ulcer in the town of Gateshead, with special emphasis on aetiology.
- Muir, A. (Glasgow), M.B., Ch.B., M.R.C.P. Research into the relationship between gastric activity and secretion and sugar metabolism.
- Savory, Mary (London), M.B., B.Ch., F.R.C.S. Research into possible uses of plasma-thrombin clot in ophthalmic surgery.
- Smith, G. H. (Dundee), M.B., Ch.B. Research into thrombosis, a clinical and pathological study.

**Mackenzie Industrial Health Lecture**

83. When the Industrial Health Education Society was wound up in 1940 it handed its surplus funds, amounting to £350, to the Association for the purpose of founding a memorial lecture, associated with the name of J. Mackenzie, on the relation of health to industry. The Council has decided to organize this as an Association Lecture to be given as part of the arrangements at Annual Representative Meetings. Members of the Association of Industrial Medical Officers and other appropriate organizations will be invited to attend. This year the lecture will be given by Dr. Donald Hunter on Wednesday, July 24.

**Bequest to the Association**

84. The Association has received notice of a bequest of £5,000 by the late Mr. E. R. Insole, and the Council proposes to establish a trust fund in his name, the income to be applied to the annual award of a scholarship to the value of £150 for research into the causes and cure of venereal disease.

**A New British Pharmacopoeia**

85. The Council has examined the proposals for a new edition of the *British Pharmacopoeia* and has presented a report and recommendations to the Pharmacopoeia Commission.

**B.M.A. Lectures**

86. The Council has resumed the scheme of giving special "B.M.A. Lectures" on clinical or scientific subjects to Branches, Divisions, or neighbouring Divisions jointly, in the British Isles. The Council extends its thanks to the following, who have given B.M.A. Lectures during the period July 8, 1945, to March 22, 1946: Mr. L. R. Broster, Prof. D. F. Cappell, Prof. H. Cohen, Dr. F. S. Cooksey, Dr. Malcolm Donaldson, Lady Florey, Dr. R. Forbes, Miss Gertrude Herzfeld, Dr. J. Clifford Hoyle, Dr. G. D. Kersley, Mr. P. H. Mitchener, Mr. C. E. Naunton Morgan, Sir Lionel Whitby, and Dr. G. Scott Williamson.

Divisions and Branches are reminded that they may have one B.M.A. Lecture during the course of the year. The lecturers are nominated by the Branch or Division, and the expenses of the lecturer are defrayed by the Council from central funds.

**MEDICAL ETHICS****Selection of Anaesthetist by Dentist**

87. In the past the Council has expressed the opinion that the dentist, like the surgeon, must be free to choose his anaesthetist. The Council has now suggested to the British Dental Association that, when a dentist chooses an anaesthetist other than the patient's doctor, it would be to the advantage of the patient and the dentist if the latter notified the patient's doctor of the arrangement, particularly when major dental operations are proposed. This suggestion has been accepted, and the Council has expressed approval of the following rule drafted by the British Dental Association for inclusion in its "Rules for Consultation":

"When an anaesthetic is advised by the dentist, it is competent for him to select the anaesthetist, but if such anaesthetist is not the patient's doctor, no objection should be taken to the patient inviting his doctor to be present. Where the operation proposed is a major one or if it is known to the dentist that the patient is under medical care, the dentist should inform the patient's doctor of the operation proposed and should invite him to be present."

The British Dental Association, in the course of a discussion on this subject, suggested that it should be regarded as the responsibility of the dentist, in the first instance at least, to deal with complications following dental operations; and subsequently submitted the following additional rule for consideration:

"On the completion of any dental operation, and especially if there is any reason to think that post-operative complications may ensue, the patient should be advised to consult the dentist immediately if such complications arise, and the dentist should take all reasonable steps to facilitate such consultation."

The Council has approved this rule but has expressed the opinion that the dentist should notify the patient's doctor of the complication and of the treatment given.

**Protection of Practices Scheme**

88. The Council has considered the ethical position of an "acting practitioner" in regard to acceptance, on the expiry of one year after the return of an "absentee practitioner," of a patient of the absentee whom he had attended during the latter's absence on national service. The Council is of the opinion that when the legal obligation terminates at the end of one year there is no continuing ethical obligation in such a case.

**List of Specialists Compiled by Lay Body**

89. The Representative Body has in the past expressed the opinion that it is undesirable that lay organizations should compile lists of specialists available to their members. A case has been reported to the Council in which it appeared that arrangements had been made which were not in conformity with the policy of the Association in regard to this matter. The Council is investigating the position with the aid of the local Branch.

**ORGANIZATION****Medical Association of South Africa**

90. The Council has had under consideration for some time the question of the relationship between the Association here and in South Africa. The Medical Association of South Africa was, before Dec. 31, 1945, a Group of Incorporate Branches within the Association. Early in 1945 the Federal Council in South Africa issued to members of the Association there a statement setting out in detail the legal relationship of the Medical Association of South Africa to the parent Association, and asked them to indicate their attitude to the following propositions.

That the Federal Council of this Association be authorized to initiate and/or take from time to time all proper steps and adopt all proper ways and means which may be found necessary or appropriate with a view to:

(a) achieving the independent and self-governing status of this Association instead of continuing the function as a corporate group of branches of the B.M.A.;

(b) securing the consent of the B.M.A. to abrogate the agreement referred to in Clause 2 of the Articles of Association of the Association;

(c) arranging that as an independent and self-governing body the Association act, so far as circumstances may from time to time permit and render desirable, in affiliation with the B.M.A. on such terms and conditions as may be found mutually acceptable to the Representative Body of that Association and to the Federal Council of this Association;

(d) in due course causing the name of this Association to be altered to "The Medical Association of South Africa."

Some 700 members in South Africa were in favour of acquiring an independent and self-governing status for the Medical Association of South Africa; 200 members were against the proposal.

The Council, after careful consideration of this problem, adopted a resolution that in order to facilitate the desire of the Medical Association of South Africa (British Medical Association) to have an independent entity of its own but affiliated to the British Medical Association, notice be forthwith given to the Medical Association of South Africa (British Medical Association) under Clause 7 of the Agreement of the 15th day of June, 1927, to exclude the Medical Association of South Africa (British Medical Association) from continuing to be a corporate group of Branches of the British Medical Association,

and, further, that notice be forthwith given under Article 16 of the Articles of Association of the British Medical Association to each Branch forming part of the Corporate Group known as the Medical Association of South Africa (British Medical Association) to exclude each such branch from continuing to be a Branch of the British Medical Association.

As a result of the action taken the Branches of the Association in South Africa ceased to form an integral part of the British Medical Association as from Dec. 31, 1945, though it is open to any doctor practising in S. Africa, whether a member of the S.A.M.A. or not, to remain an unattached member of the B.M.A.

The Council is anxious that the separation shall not impair the friendly ties and cultural relations that have existed for so long between the profession in this country and in South Africa, and is at present discussing with the Medical Association of South Africa proposals for affiliation between the two bodies. It will report further on this subject as soon as possible.

### Conference of Honorary Secretaries

91. The first Conference of Honorary Secretaries of Divisions and Branches since 1939 was held on April 4, 1946.

### Amendment of By-laws and Schedule to By-laws

92. The Council has appointed a Building Committee to deal with all questions of construction, alteration, repairs, and maintenance in connexion with the Association's buildings and the administration of the real and personal property of the Association. The appointment of this committee will necessitate an amendment to the By-laws.

Reference is made in paragraph 50 of this report to the proposed formation of a Consultants and Specialists Com-

2. That By-law 53 (b) be altered by substituting therein the word "eight" for the word "nine."

3. That By-law 56 (1) be altered by substituting therein the word "eight" for the word "nine."

4. That By-law 79 (1) be altered by inserting after the words "except the Insurance Acts" the words "Consultants and Specialists" and after the words "the Insurance Acts Committee" the words "the Consultants and Specialists Committee."

5. That By-law 79 (2) be altered by inserting after the words "the Insurance Acts Committee" the words "the Consultants and Specialists Committee."

6. That the Schedule to the By-laws be altered in manner following:

(a) Opposite the heading "Arrangements" by deleting in the fifth column the word "Group" where the same appears after the words "Consultants and Specialists."

(b) By inserting under the respective headings below set out after the entries relating to the Charities Committee the following (see Table (A)):

(c) Opposite the heading "General Practice" by deleting in the fifth column the words "Special Practice Committee" and by substituting therefor the words "Consultants and Specialists Committee."

(d) Opposite the heading "Hospitals" by inserting in the fifth column after the word "Society" the following: "1 to be nominated by the Association of Municipal Specialists, 1 to be nominated by the Association of the Honorary Staffs of the Major (non-Undergraduate Teaching) Voluntary Hospitals of England and Wales."

(e) By inserting under the respective headings below set out after the entries relating to the Hospitals Committee the following (see Table (B)):

(f) By deleting the heading "Special Practice" and all entries in the columns opposite the same.

Name of Committee	Additional Members <i>ex officio</i>	Appointed Members			Duties, Powers, etc.
		By the Representative Body	By the Council	Otherwise Appointed	
<i>A</i> Consultants and Specialists		2	2	20 members of the Association elected on a regional basis (namely, England, Wales, Scotland, and Northern Ireland) and in the manner prescribed by the Council by those members of the Association who are consultants and specialists engaged exclusively in consultant and specialist practice. 5 members of the Association elected on a national basis (comprising Great Britain and Northern Ireland) in the manner prescribed by the Council by those members of the Association who are part-time consultants and specialists. 1 by the Committee of each special group of members formed pursuant to By-law 37 1 by the General Practice Committee 1 by the Public Health Committee 1 by the Hospitals Committee 1 by the Insurance Acts Committee	To consider and to report on matters specially affecting those engaged in private consulting or specialist practice, excluding those questions which stand referred to the Hospitals, Public Health, and other Standing Committees
<i>B</i> Industrial Medicine		4	4	1 by the General Practice Committee 1 by the Hospitals Committee 1 by the Insurance Acts Committee 1 by the Public Health Committee 1 by the Consultants and Specialists Committee 2 to be nominated by the Association of Examining Surgeons 4 to be nominated by the Association of Industrial Medical Officers	To consider and to report on matters affecting the practice of medicine in industry not specifically referred to other Standing Committees The committee shall have power to co-opt 3 members if necessary to secure representation of a particular class of experience not otherwise represented on the Committee

mittee in place of the existing Special Practice Committee. Paragraph 20 of this report refers to the appointment to the Hospitals Committee of representatives of two outside bodies. As a result of the dissolution of the Branches of the Association in South Africa the number of members elected to the Council by the overseas Branches must now be reduced from nine to eight. The Council submits appropriate amendments to the By-laws and the Schedule to the By-laws to give effect to these changes.

**Recommendation:** 1. That the Schedule to the By-laws be altered in manner following: By substituting in such Schedule in the second column under the entry "Finance" the words "Insurance Acts and Building" for the words "and Insurance Acts" and by deleting from such Schedule in the sixth column under such entry "Finance" the words "and the administration of its real and personal property."

## NAVAL AND MILITARY

### War Gratuities

93. Some members of the Association serving with H.M. Forces have expressed dissatisfaction with the scale of war gratuities. The Council considered a factual statement showing the gratuity to which a medical officer in the R.A.M.C. was entitled in the 1914-18 war as compared with the gratuity in the 1939-45 war, and came to the conclusion that no useful purpose would be served by urging a general increase in gratuities.

It appears that a medical officer who is released under Class B at the instigation of the Central Medical War Committee on grounds of urgent civil needs is entitled to 21 days' leave as compared with 56 days' leave granted to an officer released under Class A. Leave pay forms part of the gratuity payment. The Council made representations to the

War Office that a medical officer released under Class B should not lose any part of the leave pay to which a medical officer released under Class A is entitled. The Department was unable to make any concession.

#### Clinical Rehabilitation of Serving Officers

94. The Council has considered Minute 147 of the A.R.M., 1945, which expressed dissatisfaction with the period allowed for the refresher courses available to demobilized medical officers previously engaged in general practice. Representations were made to the Ministry of Health upon this and a number of other questions arising from the Government's scheme for the clinical rehabilitation of medical officers on release.

### FINANCE

95. The year which ended on Dec. 31, 1945, provided the Association with another opportunity to consolidate its financial position in anticipation of the increasing scale of expenditure made necessary by post-war planning.

#### Balance Sheet

96. Apart from additions to the Reserve Funds created to meet recurring expenditure, it has been thought prudent to allocate a substantial part of the surplus to the General Contingency Reserve, which now stands in the Balance Sheet at £100,000. The Fund previously described as the Reserve to meet redecoration and dilapidations now appears as the Building Reserve as it also covers the cost of reinstating and completing the South Wing. Surplus moneys have been invested in gilt-edged stock in order that funds may be readily available. The practice of writing down the assets of the Association on a generous scale has been continued.

#### Income and Expenditure Account

97. At the close of 1945 the membership stood at 51,508 and the revenue from subscriptions reached the record figure of £113,653. The average subscription received for the year was £2 4s. 2d. There is still a large proportion of members enjoying the service subscription rate.

The de-requisitioning of the air-raid shelter by the local authority resulted in a small decrease in the rents collected from tenants in the Association's building. The Council has recently approved an increased rental scale, the effect of which will only become obvious when new tenancies are negotiated. There was a large increase in central meeting activity during the past year with a corresponding increase in expenditure. A Special Representative Meeting was called in May, 1945, to discuss the proposals in connexion with the National Health Service. Capitation grants increased in proportion to the rising membership, but the full effect of the return of the Service members to their home branches will be reflected in the accounts of the coming year.

Apart from the special items of expenditure, the Association general expenses have not varied to any great extent. In accordance with the arrangements approved by the Council the Association bore an equal proportion of the expenses of the Public Relations Department, which included during the past year the cost of the film "The Family Doctor." There was a slight increase in the establishment costs. General cleaning and maintenance of the building are still restricted, but every opportunity is taken to obtain authority to carry out urgent repairs and redecoration. There was a small reduction in the rates paid to the local authority. The increased expenditure on postages and stationery has followed the development of the work of the Association in all departments.

#### Journal Account

98. For the second time in recent years the revenue from advertisements and sales of *Journals* has exceeded the cost of producing the *Journal*, with the result that a balance of £17,181 has been transferred to the Income and Expenditure Account. This highly satisfactory result has been achieved by an increase of over £25,000 in the revenue arising from increased advertisement rates in spite of a decrease in the number of pages from 1,129 in 1944 to 1,068 in 1945. A substantial increase in the number of copies was again necessary, the number rising from 2,658,850 in 1944 to 2,795,700 in 1945.

### Office Staff Superannuation Fund and Trust Funds

99. The financial position of the office staff superannuation fund is sound, the market value of the investments on Dec. 31, 1945, standing at £49,477. All the prize funds hold substantial cash balances, which will enable them to pay the prizes which will be awarded during 1946. The amount of subscriptions and donations collected by the B.M.A. Charities Trust Fund show a satisfactory increase, though no bequests were received during the past year.

#### Estimate for the Year 1946

100. It is estimated that the revenue of the Association during the coming year will increase over that of 1945. With an estimated additional revenue from subscriptions and the income from rents and investments it is likely that the total receipts for the year will be approximately £142,000. It is clear that as a result of the Association's activity in connexion with Government proposals, there will be heavy increases in expenditure in 1946.

### SCOTLAND

101. Dr. A. F. Wilkie Millar and Dr. George MacFeat were reappointed chairman and deputy chairman of the Scottish Committee for session 1945-6.

#### Deaths of Members of Committees

102. The Committee received with great regret reports of the deaths of Mr. P. F. McFarlan, Stirling, a member of the Hospitals Subcommittee and Scottish Medical Consultative Committee, and Prof. James Hendry, Glasgow, a member of the Scottish Medical Consultative Committee.

#### Reorganization of Dumfries and Galloway Division

103. A proposal is under consideration by the Scottish Committee for the reorganization of the Dumfries and Galloway Division, including the formation of a separate Division for Western Wigtownshire.

#### Maternity Services (Scotland) Act, 1937

104. The Scottish Committee was asked by the Department of Health for Scotland to use its influence in obtaining the co-operation of the doctors in the following areas, who had so far declined to accept service under the Act: Selkirkshire, Dundee, Clydebank, Lewis, and Bo'ness. The doctors in Bo'ness have now agreed to accept service.

105. The Department of Health asked for the views of the Scottish Committee as to whether an insured woman applying for services under a Maternity Services Act scheme should be required, as hitherto, to select her insurance doctor if he had agreed to render service under the scheme. The Department considered that on balance it was preferable to maintain the stipulation. The Scottish Committee expressed the opinion that there should be no interference with the right of insured women to have free choice of doctor.

The Glasgow Division in association with the Scottish Committee made representations to the Department of Health regarding the refusal of Glasgow Corporation to operate the Maternity Services Act. At a later date a deputation from the Division met the Health Subcommittee on Clinical Services and requested that the corporation should bring into operation the provisions of the Maternity Services (Scotland) Act, 1937. The Health Subcommittee have intimated that they do not propose to take any action in the matter.

#### Fees Payable to Medical Witnesses, etc.

106. The committee has considered the fees presently payable to doctors in various judicial and semi-judicial processes and has decided that the Crown Office should not be approached till the result of the negotiations presently proceeding with the Home Office in England have been intimated.

#### Proposals for a National Health Service

107. At the meeting of the Scottish Committee held on Jan. 23, 1946, it was reported that the Secretary of State for Scotland had invited the Scottish Negotiating Committee to

meet him at St. Andrew's House to discuss in confidence the proposals of the Government for a National Health Service in Scotland. The proposals were considered in detail by the Scottish Committee.

### Central Midwives Board

108. The Scottish Committee renominated Dr. W. Leslie Cuthbert, Stirling, and Dr. D. Dale Logan, Lanarkshire, as members of the Central Midwives Board for Scotland for a period of five years from Feb. 1, 1946.

### WALES

109. The Welsh Committee held its first meeting since the beginning of the war at Shrewsbury and appointed Dr. H. R. Frederick as its chairman. The Council approved suggestions for the reorganization of the Divisions in the area of the North Wales Branch, and is already taking steps to resuscitate the South Caernarvon and Merioneth Division. Although the committee did not meet during the war, its Contract Practice Subcommittee continued its activities, and is at the present time engaged in negotiations in the Pontypridd and Aberkenfig areas.

The committee has placed on record its appreciation of the services rendered to it by the late Dr. W. E. Thomas.

### OVERSEA BRANCHES

#### Colonial Advisory Medical Committee

110. The Secretary of State for the Colonies is advised in the formulation of policy by a Central Advisory Committee which is composed of representatives of a number of bodies in this country interested in tropical medicine. The Council is suggesting to the Colonial Office that the Association, which represents the medical profession in the Colonies, should be represented on that committee, and is asking the Secretary of State to consider the appointment of a representative.

#### Opportunities in the Colonial Medical Service

111. The Council considered a complaint from one of the East African Colonies that the statement, in advertisements of vacancies in the Colonial Medical Service, that the Service afforded "ample opportunities for work in special branches of medicine and surgery, in public health, and in medical research," was misleading because, in fact, few such opportunities existed. The Council invited the observations of the Colonial Office and of other Oversea Branches on the matter. The limited evidence available certainly does not show that there is universal dissatisfaction about these matters in the Colonial Medical Service, and it may be that some of the complaints result from restrictions necessarily imposed by the war. It does appear, however, that in a few areas opportunities are by no means all that could be desired. The Council has therefore explained to the Colonial Office the causes of dissatisfaction expressed by Oversea Branches and has asked it to consider the possibility of providing better professional opportunities in the territories concerned.

#### Payment to Interned Doctors in Malaya

112. Complaints of unfair treatment by the Colonial Office have been made by a number of doctors in private or estate practice in Malaya who had been mobilized as members of the Malayan Auxiliary Service and were captured and interned by the Japanese. They claim that arrangements should be made for them in regard to salary, leave pay, and passages similar to the arrangements made for medical officers who were normally in whole-time Government employment.

The matter was taken up with the Colonial Office, and eventually the Colonial Office issued a statement to the effect that "those members of the Civil Defence Services of Malaya and Hong Kong now released from internment, who are not eligible as Government servants or otherwise for accrued pay during internment, may on application be granted *ex-gratia* payments equivalent to three months' pay of their Civil Defence posts."

The Colonial Office was informed that the Association could not agree that this arrangement was an equitable one. Subsequently, the Colonial Office issued a memorandum stating:

It has been decided that *ex-gratia* payments equivalent to accrued pay for the period of internment, at the rate appropriate to the rank of the individual, may on application be made to members of the Civil Defence Services of Malaya and Hong Kong who were interned, subject to: (1) a deduction of 10%; (2) a maximum of £1,500 in any one case; (3) deduction of *ex-gratia* payments already made to members themselves.

The Council is dissatisfied with this decision and is continuing to press for more generous treatment of the doctors concerned.

#### Temporary Registration in Trinidad

113. A complaint was received from Trinidad concerning the temporary registration, for the purpose of special Government schemes, of medical officers from Canada and America. As these registrations were to be authorized by the Governor in Council the matter appeared to involve the status of the local medical board as the sole authority to determine whether medical qualifications are of a sufficiently high standard to justify registration. Representatives of the Council discussed the position with representatives of the Colonial Office, who believed that some misunderstanding must have occurred and promised to make inquiries. The Branch has been asked to state whether the difficulty has now been resolved.

#### Local Salaries Scales

114. Representatives of the Council have discussed with representatives of the Colonial Office complaints about inadequate salaries scales received from the British Guiana Branch and the Malta Branch. One of the outstanding difficulties in the British Guiana scale is that the salaries of the Director and the Deputy Director of Medical Services are seriously inadequate. The Malta Branch was advised to prepare a detailed memorandum on the present position and its recommendations. This has recently been submitted through the Governor to the Secretary of State.

#### Southern Rhodesia School Medical Service

115. The Council's attention has been drawn to the inequality of salaries paid to men and women medical officers in the Southern Rhodesia Medical Service. A woman medical officer complained that, while a woman school medical officer is placed in a junior grade with a salary of £600-£900, without reference to experience, qualifications, or length of service, male school medical officers engaged on exactly the same work are in a senior grade on a salary of £1,000-£1,250. There is some conflict of evidence about the equality of the actual duties performed. The policy of the Association of equal pay for equal work has, however, been brought to the notice of the High Commissioner for Southern Rhodesia, but no satisfactory reply has yet been received.

H. GUY DAIN,  
Chairman.

### APPENDIX I

#### REPORT ON "GENERAL PRACTITIONER" HOSPITALS

##### I. Preliminary

1. The following resolution was adopted by the Annual Representative Meeting in 1944:

"That this meeting urges the importance of the preservation and development of the small general hospitals and recommends to the Council that they give their earnest consideration to making these hospitals staffed by general practitioners the nuclei of one type of the future health service centres."

2. This resolution was referred to the Hospitals Committee, which appointed a special subcommittee to consider it. The members of the subcommittee were R. L. Newell (chairman), Geoffrey Bourne, P. W. L. Camps, J. Ferguson, A. S. Gough, W. S. Macdonald, L. J. Picton, and N. E. Waterfield. L. J. Picton resigned his membership, having been able to attend only one meeting.

3. The opinions and recommendations of the subcommittee have been approved by the Hospitals Committee and the Council and are presented in this report. The arguments in favour of providing facilities for the observation, diagnosis, and treatment of patients in hospital by general practitioners are first considered, and the form that this provision should take is then discussed in some detail. The resolution of the Representative Body has been interpreted as an expression of the frequently stated need for hospital beds in which patients may remain under the care of their family doctors when suffering from conditions the treatment of which is within the normal scope of general practice. A comprehensive survey of the relations between general practice and the hospital services as a whole has not, therefore, been attempted; and the Council wishes to stress at the outset the fact that, in confining its attention to the "general practitioner" hospital, it does not intend to suggest that there is no place for specially qualified general practitioners in the work of the major hospitals. If little is said here about the provision of opportunities for the "part-time consultant," it is because this appeared to be scarcely relevant to the question of the hospital facilities necessary to enable the general practitioner to function efficiently as a general practitioner. It is the latter question that is discussed in this report.

## II. The Need for "General Practitioner" Hospitals

4. There is much to be said in favour of a more extensive provision of hospitals in which patients may remain under the care of general practitioners. Such hospitals enable and encourage the general practitioner to assume fully his proper professional responsibilities. They afford him valuable opportunities for observation of patients; they place at his disposal more complete facilities for the carrying out of diagnostic tests than are otherwise readily available to him; and they make continuity of treatment possible in cases in which removal to hospital is necessary because of domestic conditions—such as lack of skilled nursing—and not because treatment outside the scope of general practice is required. The importance of such continuity is emphasized in the Association's publication, "A General Medical Service for the Nation," where the following statement is made:

"It commonly happens to-day that, for a social reason such as unsatisfactory home surroundings, a patient is admitted to hospital for a condition which in a more fortunately circumstanced patient would be treated at home by the patient's own doctor. It is contrary to the interest of the patient and damaging to the efficiency of general practice if social conditions lead to a discontinuity of medical treatment."

5. The same view finds expression in a number of more recent publications. The following passage, for example, occurs in the Hospital Survey of South Wales and Monmouthshire by Dr. A. Trevor Jones, Prof. J. A. Nixon, and Prof. R. M. F. Picken:

"The main advantage of the system whereby general practitioners serve on the staffs of hospitals is the extremely close and continuous supervision over patients during all stages of their illness. When the general practitioner is responsible both in and out of the hospital this supervision is easy, and it is in conformity with the patient's natural wish to have his own family doctor in charge of his case during his stay in the hospital ward. Continuity of treatment is a desirable object to aim at and, in so far as the small local hospitals achieve this object by reason of the fact that the patient's family doctor is also in charge of the hospital bed, it is an argument in favour of their existence and of their development within certain defined limits. The question will become of increasing importance if the tendency to hospitalize less seriously ill patients develops."

6. Not the least of the benefits to be derived from the "general practitioner" hospital are the opportunities provided for collaboration between local practitioners and the educational value of regular contact with visiting consultants. These aspects of the matter also have received attention in a number of recent reports. In "A General Medical Service for the Nation" it is pointed out that an association with hospital, by reason of the contacts it affords with fellow practitioners and the team work it involves, stimulates the general practitioner to a higher standard of efficiency, with consequent benefit to the community. The recently published report of the Volims Com-

mittee refers to the value of the small local hospital as a "meeting ground for men and women engaged in general practice, for the exchange of ideas and for the comparison of methods of treatment." Again, the importance of such collaboration is stressed in the Interim Report of the Medical Planning Commission. And in the report on "Some Aspects of the Post-war Hospital Problems in London and the Home Counties," issued by the Joint Committee of King Edward's Hospital Fund for London and the Voluntary Hospitals Committee for London, the matter is thus summarized:

"Unless the general practitioner is provided with a local hospital where he can himself attend his patient, the quality of the whole medical service will suffer, and there will occur a divorce between the work of the general practitioner and of the hospital services. Arrangements such as those advocated by the Goodenough Committee and other bodies for those taking part in the work of the general and special hospitals, by means of clinical assistantships, etc., while highly desirable in themselves, are not enough. Close association with the visiting consultant in the care of his patient at the cottage hospital will be of real benefit to doctor and patient alike."

7. There are other advantages to be found in local hospitals staffed by general practitioners. The admission to such hospitals of patients who require skilled nursing makes for economy in the use of the limited number of nurses available for the general population in any area. The homely atmosphere of these small hospitals is appreciated by the patients, as well as the proximity of the hospitals to their homes and their consequent accessibility to visiting relatives and friends. Moreover, the extension of hospital provision of this kind will benefit the larger general hospitals by relieving them of cases for which their special resources are not required.

8. The provision of hospital facilities for general practitioners is sometimes discussed as if it were solely a problem of the rural areas. In the Hospital Survey of London, for example, Dr. A. M. H. Gray and Dr. A. Topping, while stressing the importance of the general practitioner being associated with hospital work, suggest that it is only in "the more rural areas" that there is a place for the "general practitioner" hospital. Clearly, the advantages to the general practitioner of being able to treat his patients in hospital in suitable cases are no less important in the towns than in the country districts, though the question of how the necessary provision may best be made in the thickly populated urban areas certainly calls for special consideration.

9. One method which deserves examination is the establishment of special blocks for general practitioners at the large urban hospitals. The chief objection to this arrangement is that for certain practitioners and patients it would be inconvenient geographically. It has been suggested that there might also be administrative difficulties due to the large number of practitioners who would attend intermittently, but in view of the successful organization of private blocks which are visited by numerous consultants it is not thought that such difficulties would prove insuperable.

10. Smaller units for the patients of relatively few doctors, on the other hand, are open to the possible objection that they would be uneconomical; but, as is pointed out in the Hospital Survey of South Wales and Monmouthshire, "this difficulty might not be serious if these units were part of one hospital organization with common purchasing and services and interchangeable nursing and ancillary staff, and especially if the beds were established at a health centre for all the medical services of the locality." However this problem may be solved, it is to be understood that, except where the contrary is indicated, the arrangements recommended in the following paragraphs are regarded as desirable in all types of area, and that the "general practitioner" hospital might be a special block of a larger hospital and need not always be a separate institution.

## III. The Work of "General Practitioner" Hospitals

11. The "general practitioner" hospital should be open to every general practitioner in the locality which it serves and should not have a restricted staff. It is clearly desirable that the facilities here recommended, designed as they are to enable the general practitioner to discharge his proper functions completely and efficiently, should be available to all. Local dental prac-

tioners also should have access to the hospital for the performance of dental operations in cases in which a short period of post-operative care in hospital is desirable.

12. There should be a committee composed of all the medical and dental practitioners attached to the hospital. This committee should meet regularly to consider professional questions affecting the hospital, and it should be adequately represented on the governing body.

13. The cases which may suitably be admitted to such a hospital are of various types. First, there is the medical case not needing elaborate radiological or pathological investigation but requiring observation under hospital conditions or nursing such as cannot be provided at home. Secondly, there is the case calling for minor surgical procedures within the normal competence of the general practitioner, or for dental treatment followed by in-patient care. Thirdly, although opinions differ as to the desirability of admitting maternity cases to the smaller local hospitals, it may be advisable to include provision for normal maternity cases where there are inadequate facilities for such patients to be attended by their own doctors in special institutions. Some beds should be provided also for chronic sick or incurable patients, admitted either from their homes or from larger hospitals when there is no advantage to be gained from continued treatment there. As is pointed out in the Hospital Survey of London, the experience and outlook of the general practitioner make him more acceptable than the junior resident to patients of this type. Finally, post-operative and other convalescent cases, on discharge from larger hospitals, might with advantage be admitted for a period to the local hospitals under the care of their own doctors if not requiring treatment at special rehabilitation centres.

14. The activities of the "general practitioner" hospital may include also out-patient consultations with the visiting consultants and specialists referred to in Section V below. There should be fully equipped out-patient consultative clinics where such facilities are not conveniently available at other local hospitals.

15. While there is a type of local hospital, open to all the general practitioners of the district, at which major surgery is undertaken, the work of the "general practitioner" hospital envisaged in this report should not, in general, include the routine performance of major surgical operations. In the more remote rural areas it may, at least for a time, continue to be necessary for major surgical emergencies to be dealt with in "general practitioner" hospitals by suitably qualified general practitioners resident locally; but the improvement of ambulance and transport services should increasingly permit of serious operations being carried out in more suitable surroundings, where adequate equipment and staff, including the best nursing and other ancillary services, are available.

#### IV. Equipment and Ancillary Staff

16. From what has been said above as to the work of the "general practitioner" hospital it follows that the equipment necessary is of a comparatively modest description. The primary essential is the provision of a suitable number of beds for male and female adult patients and for children. Maternity cases, if admitted, should of course be segregated, and it is desirable that separate wards should be provided also for the elderly chronic sick. In addition there should be suitably equipped accommodation for such out-patient consultative clinics as may be necessary and for out-patient treatment by massage and other methods of physical medicine. It is of particular importance that the many patients who require physiotherapy in its various forms should be able to obtain such treatment within easy reach of their homes.

17. A small theatre must be included for the treatment of minor surgical conditions and, in certain rural areas, of major surgical emergencies; and the necessary equipment for dental surgery must also be provided. There should be a small laboratory where the simpler pathological examinations can be carried out. The general practitioner who wishes to do so should be at liberty to conduct his own pathological investigations, but as many practitioners lack the time for such work and the opportunity for practice in the procedures required infrequently, an expert technician should be made available by the regional

pathological service and should work under the supervision of a visiting pathologist.

18. Similarly, the services of a trained radiographer, supervised by a visiting radiologist, should be available. The provision of simple diagnostic facilities, both pathological and radiological, will enable the general practitioner to take his proper share in the diagnosis of his own cases which do not require the more elaborate methods of investigation available at the larger hospitals.

19. For the purpose of training nurses the "general practitioner" hospitals should be grouped with the larger hospitals, the latter accepting probationers partly trained in the former. The district nursing service might well be based on the small local hospitals. When provision is made for maternity cases at least one member of the nursing staff should be a fully qualified midwife. The ancillary staff should include also one or more trained physiotherapists, and suitable clerical assistance is essential in order that adequate records may be kept.

20. The reorganization of the ambulance services is part of the general question of hospital planning. Suffice it to say here that it is important that transport facilities should be readily available for conveyance of patients to the "general practitioner" hospitals and, when necessary, from these to other hospitals.

#### V. Consultant Staff

21. At every "general practitioner" hospital the services of consultants should be regularly available. The consultant staffs of the larger centres will not normally be able to visit the small outlying hospitals, which should be linked with suitable hospitals for the purpose of consultant and specialist services. A physician, a general surgeon, an obstetrician and gynaecologist, a radiologist, and a pathologist should attend at regular intervals, and other consultants should be available when necessary. The pathologist and radiologist should not merely furnish written reports but should also be available for personal consultation.

22. The functions of the visiting consultant will be to assist in diagnosis and to advise regarding treatment. He will not have charge of beds, and he will see both in-patients and out-patients only at the invitation of their doctors. He will not himself undertake treatment in the "general practitioner" hospitals, except in emergencies. Patients requiring constant supervision by consultants will be transferred to suitable hospitals by arrangement between the visiting consultants and their own doctors. For out-patient consultations the appointments system should be used.

#### VI. Conclusion

23. The methods whereby hospital facilities of the kind here envisaged may best be provided in different types of area should be investigated in connexion with experiments in health-centre organization. It is important that such hospital provision should be made in all areas, whether in association with or apart from any health centres of the "communal surgery" type that may be established. In the rural area and perhaps also in the less crowded urban area, where the doctors are fairly widely distributed, the setting up of scattered health centres seems likely to prove uneconomical, and the establishment in a central position of a "general practitioner" hospital, which may be regarded as a "diagnostic" health centre with the addition of in-patient facilities, may be the only new development in the organization of general practice that is necessary and practicable.

24. For various reasons, and particularly because of the present building restrictions and the inadequate supply of consultants and specialists, many years must pass before full provision of hospital facilities such as are recommended in this report can be made throughout the country. It is perhaps well, however, that progress should be gradual, since there are certain matters—for example, the number of "general practitioner" hospital beds likely to be required for a given population—which are difficult to judge in the light of present knowledge and can be ascertained more exactly only as a result of further experience. Meantime, the suggestions contained in this report may serve as a guide in planning the centrally arranged experiments which should precede the full development of local schemes.

## APPENDIX II

## Motions Referred to Council by A.R.M., 1945

Minute of A.R.M.	Subject	Paragraph of Council's Report
23	Medical education .. .. .	8
24	Pamphlet on "Health" .. .. .	18
26	International relations .. .. .	9
37	Fees for treatment of ex-regular firemen	37
40	Assistance to demobilized officers ..	31
42	Medical War Relief Fund .. .. .	13
43	Fees for medical witnesses .. .. .	43
46 & 47	Doctors' cars .. .. .	35
48	Purchase tax on doctors' cars .. ..	36
50	Composition, functions, and procedure of the G.M.C. .. .. .	44
55	Local advisory committees on indus- trial health .. .. .	32
56	Supplementary clothing coupons .. ..	33
60	Night calls for emergency cases .. ..	42
65	Reference to Regional Medical Service	48
70	"General practitioner" hospitals ..	19, & App. I
71	Part-time consultants and specialists on hospital staff .. .. .	51
74	Medical, nursing, and domestic staffs	22
84	National Health Service } Reported to Negotiating	
92	National Health Service } Committee but no action	
95	National Health Service } taken yet.	
98	Safeguarding private practice under 100% National Health Service ..	30, 52
105	Scottish Assistant Secretary .. .. .	3
109 & 100	Education Act .. .. .	75
114	Education Act .. .. .	75
113	School medical reports .. .. .	73
117	Care of chronic sick .. .. .	21, 71
119	Askwith Agreement .. .. .	58-62
123	Pasteurized milk .. .. .	70
124	Vaccination fees .. .. .	68
125	National maternity service .. .. .	66
127	National maternity service .. .. .	66
130	National maternity service .. .. .	66
131	National maternity service .. .. .	66
132	Equal pay and cost-of-living bonus ..	63
134	Pensionable age for women .. .. .	64
135	Grant of cost-of-living bonus to super- annuated officers of local authorities	65
136	Collaboration between Association and medical bodies producing reports on nation's health .. .. .	6
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## SPECIAL GROUPS OF THE B.M.A.

Practitioners returning from the Forces may like to be reminded that the Council of the B.M.A. has established the following special Groups of members who have distinctive professional interests and who, either by reason of their paucity of numbers or through local distribution, are unable to obtain adequate representation of those interests through the Divisions and Branches. At the present time the following Groups are in existence:

*Consultants and Specialists Groups for England and Wales, Scotland, and Ireland*, composed of members of the Association living in England and Wales, and in Scotland and Ireland, respectively, who sign a declaration that they are not engaged in general practice in any form but are practising exclusively as consultants or specialists and who (a) are not whole-time officers in the public health service (whole-time consultants and specialists in the Council Hospital Service are not excluded from eligibility for membership of the Group); (b) are not officers on the active list of the Navy, Army, or Air Force (this exception does not exclude from eligibility for membership consultants and specialists serving with H.M. Forces who would otherwise have been eligible).

*Spa Practitioners Group*, composed of those members of the Association who regularly prescribe the mineral waters or baths of the spas in which they reside or who are on the staff of a hospital or clinic where the use of the local mineral waters is part of the routine treatment.

*Consulting Pathologists Group*, composed of those members of the Association (not being members of the public health service) working in an institutional or private pathological laboratory engaged in examining and reporting on specimens for clinical purposes.

*Practitioners of Physical Medicine Group*, composed of those members of the Association who have specially studied the values of physical methods in the prevention and cure of disease and whose practice is predominantly devoted to the application of these methods.

*Radiologists Group*, composed of those members of the Association who are engaged predominantly in the practice of radiology.

*Group of Practitioners of Psychological Medicine*, composed of those members of the Association engaged predominantly in the practice of psychological medicine.

*Group of Full-time Non-professional Medical Teachers, Laboratory and Research Workers*, composed of those members of the Association engaged full-time as non-professional medical teachers, laboratory or research workers.

*Ophthalmic Group*, composed of those members of the Association engaged predominantly in the practice of ophthalmology.

*Group of Orthopaedic Surgeons*, composed of those members of the Association engaged predominantly in the practice of orthopaedic surgery.

*Group of Dermatologists*, composed of those members of the Association engaged predominantly in the practice of dermatology.

During the war it was not practicable to hold conferences of members of the Groups, but it is hoped now to resume the full Group machinery and to hold conferences each year. The views of the Groups will also soon be required in connexion with the new National Health Service.

Each Group appoints a committee, which conducts the business of the Group. The Group committee considers the opinions expressed at meetings of the Group and may also take the opinion of the Group members by post. Its findings are placed before the Special Practice Committee, and through the latter before the Council and Representative Body. Each Group Committee is represented on the Special Practice Committee, and there is special provision in respect of attendance at meetings of other committees and the Council of representatives of a Group Committee when matters affecting the Group are being considered.

Members of the B.M.A. who are eligible for membership of any of the Groups are invited to apply to the Secretary.

## GROUP OF DERMATOLOGY IN THE B.M.A.

The newly formed Group of Dermatology held its first meeting at B.M.A. House on March 21, and Dr. R. M. B. MacKenna was appointed chairman. It was reported to the meeting that the B.M.A.'s rules for the government of groups provided for the appointment of a Group Committee of not fewer than six members—the number to be subject to the approval of the Council of the Association—which would hold office for three years and be elected by postal vote from among the members of the Group as a whole or, if so decided by the Council, in regional constituencies. The general view of the meeting was that regional constituencies would form the most appropriate basis for a representative Group Committee, and it was decided to recommend to the Council that the Group Committee should be constituted of nine members directly elected on a territorial basis by members of the Group practising in the following regions: London, 4; Provinces, 3; Scotland, 1; Northern Ireland, 1.

The chairman reviewed the circumstances which had led to the formation of a Group of Dermatology, the object being to

ensure the most complete representation of the interests of the specialty under the aegis of the B.M.A., particularly in the light of current legislation. Among matters discussed and referred for early detailed consideration by the Group Committee were: (1) Employment of junior specialists in dermatology released from the Forces; (2) arrangements for teaching Service medical officers who wish to become specialists in dermatology as distinct from venereology; (3) the suggestion that in future the Services have specialists in dermatology on their regular establishments; (4) the institution of a Diploma in Dermatology, with special reference to arrangements for post-graduate teaching; (5) the institution by the Council of the B.M.A. of research scholarships in dermatology; (6) the creation of salaried appointments in dermatology at universities, with a view particularly to the employment of released Service medical officers with experience of dermatology.

## Correspondence

### The Guarantee Fund

SIR,—How can anyone conscientiously give a guarantee to subscribe at the time of need to a fund intended "to afford help to practitioners who suffer hardship as a result of their loyalty to the cause of the profession"? It should be obvious that should the day ever come when some are in need then the purses of us all will certainly be much depleted. How can anyone know that he will be able to make any payment during the actual progress of a grim struggle?

A fighting fund should surely be a collection of hard cash, not one of possibly vain promises. I submit that our support is needed, not by a Guarantee Fund, but by the National Insurance Defence Trust. My panel committee will pay the final tenth of its share of £1,000,000 at the beginning of the next quarter—in other words, most of us in West Bromwich will have actually paid, over a period of two and a half years, four or five times the minimum sum which we are now being asked to promise. Is there any valid reason why all other panel committees should not immediately catch up with us? And is there any reason why a definite subscription fund should not now be opened to receive payments from sections of the profession other than panel practitioners?

With our very freedom in jeopardy, and money probably needed to save it, why are we so parsimonious that we can meet the need only with promises to pay (if we then still have it to pay)? I believe that if we mean business £1,000,000 (with a further quarter, half, or whole million from the non-panel people) should be in the B.M.A. coffers now.—I am, etc.,

West Bromwich.

D. SAKLATVALA.

### Release from the R.A.F.

SIR,—The continued slowness in release of R.A.F. medical officers compared with the other Services is causing us increasing concern. We are not in any way satisfied with the vague replies and assurances given to questions in Parliament, and are of the opinion that persistent lack of foresight and thoughtlessness have given rise to the present marked disparity. Why, for instance, are 280 doctors being recruited into the Army during the current half year and only 110 into the Air Force, considering that the Army is already 10 groups ahead of us and will precede us by 14 groups by the end of June? Surely there can be no easier method of rectifying this inequality than by directing all new entrants into the R.A.F. until a stable point is reached. No great administrative difficulties would be incurred, so far as we can see. Why also cannot doctors over the age of 31 be directed into the Services? Many of us who have served for close on five years and have not yet been released are over that age already. It is noted that specialists, on the other hand, are being recruited up to the age of 40 in an attempt to meet their release requirements.

We feel that if this disparity is allowed to continue it will seriously jeopardize our chances of finding, by fair competition, the type of job in civilian life which we may desire. We are convinced, therefore, that R.A.F. medical officers should be

given a more satisfactory explanation of the underlying circumstances and be informed of definite steps being taken to remedy them. We regret we cannot sign our names.—We are, etc.,

"33 AND 37."

SIR,—When a fixed ratio of medical officers to total personnel was imposed recently the mass exodus from the Navy and Army clearly showed that these Services had a ridiculously high proportion of doctors. Equally, it demonstrated that during the years of hostilities the average R.A.F. medical officer has had to care for considerably higher numbers than has his naval or military colleague. With this must be considered that promotion in the R.A.F. has been non-existent for years, and that our administration is by far the most cumbersome. To compensate for this we now learn that by June the Naval M.O. of the same age will have served three years eight months, and the R.A.M.C. officer one year six months, less than his fellow in the R.A.F.

In answer to a question on the delay in demobilization of R.A.F. medical officers Mr. Bevan promised "to consider the matter in the light of any recommendation the Medical Personnel Priority Committee might make." Might I suggest to this august (and seemingly somnolent) body that it can immediately, and easily, rectify the disparity in release between the three Services. Approximately 1,500 who qualified in medicine last summer have so far escaped military service. Conscript 1,000 of these and send them directly to units; one week later release the present incumbents of these units. By eliminating the week's tomfoolery of training, which we had to endure during the war years, at least one additional officer could be freed to perform station duties.

If we are ever to take our places in the professional spheres to which many of us have aspired for weary years it is of paramount importance that we should be released before the commencement of the next academic year. We have received platitudes and condolences from Service and civil authorities *ad nauseam*. Despite this the sole action seen hitherto has been an ever-increasing gap in release rates between R.A.F. and the other Services. The situation is intolerable and demands immediate redress of this unilateral victimization.—I am, etc.,

"FIFTH YEAR."

### R.A.F. Release Questionary

SIR,—The Air Ministry has just announced the advance notification of releases for the months of April and May. This notice, which, according to the popular press, shows a "further speed-up in the already speedy R.A.F. release," does, in fact, show a reduction in rate for medical officers, of whom Group 32 only is to be released in May. This means that medical officers are now behind the general release rate for other ground officers, as well as being (at this rate of release) at least a year behind their colleagues in the Navy and nine months behind those in the R.A.M.C. In view of this disgraceful travesty of the principle of age and service the following questions seem pertinent and need answering by the appropriate authority.

1. Why has medical recruiting for the Army been allowed to continue during the last nine months? Even if the present state of affairs was not foreseen, it has been obvious since Jan. 1. It is clear that all non-specialist medical recruits should, without exception, be drafted into the R.A.F. until the releases are evened out.

2. Who is the responsible authority for the allocation of medical recruits? Why has he (whoever he may be) not come forward and given some explanation of his policy on the matter? Or is there no single authority: is it a case of a tug-of-war between the Services with the doctors being used as the rope?

3. The C.M.W.C. is, in its own words, "advisory" on recruiting. Has it taken any steps to co-opt or invite ex-Service consultants to assist in its deliberations? Has it heard the opinions of Dr. Conybeare, or Sir Charles Symonds, or Sir Stanford Cade, or of any others in like position?

4. Has the B.M.A. or the Government taken any steps to protect the interests of those who, like ourselves, are retained in the R.A.F., and who see released Army M.O.s with less

service than ourselves establishing themselves in the districts in which our practices lie?

5. Has the B.M.A., on our behalf, taken counsel's opinion as to whether, now that the Government has broken its contract with us over release, our own contract to serve for the duration of the present emergency remains binding?

There are many other relevant points, but they can wait until it is seen whether any replies are vouchsafed to those already enumerated. We enclose our names, but would ask you to respect our anonymity.—We are, etc.,

"TWO MORE R.A.F. MEDICAL OFFICERS."

## Association Notices

### Middlemore Prize

The Middlemore Prize consists of a cheque for £50 and an illuminated certificate, and was founded in 1880 by the late Richard Middlemore, F.R.C.S., of Birmingham, to be awarded for the best essay or work on any subject which the Council of the British Medical Association may from time to time select in any department of ophthalmic medicine or surgery. The Council is prepared to consider the award of the prize in the year 1947 to the author of the best essay on: "The Aetiology and Treatment of Chronic Iridocyclitis." Essays submitted in competition must reach the Secretary, British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1, on or before Dec. 31, 1946. Each essay must be signed with a motto and accompanied by a sealed envelope marked on the outside with the motto and containing the name and address of the author. In the event of no essay being of sufficient merit the prize will not be awarded in 1947.

### Sir Charles Hastings Clinical Prize

The Sir Charles Hastings Clinical Prize, which consists of a certificate and a money award of fifty guineas, is again open for competition. The following are the regulations governing the award:

1. The prize is established by the Council of the British Medical Association for the promotion of systematic observation, research, and record in general practice; it includes a money award of the value of fifty guineas.

2. Any member of the Association who is engaged in general practice is eligible to compete for the prize.

3. The work submitted must include personal observations and experiences collected by the candidate in general practice, and a high order of excellence will be required. If no essay entered is of sufficient merit no award will be made. It is to be noted that candidates in their entries should confine their attention to their own observations in practice rather than to comments on previously published work on the subject, though reference to current literature should not be omitted when it bears directly on their results, their interpretations, and their conclusions.

4. Essays, or whatever form the candidate desires his work to take, must be sent to the British Medical Association House, Tavistock Square, London, W.C.1, not later than Dec. 31, 1946. The prize will be awarded at the Annual General Meeting of the Association to be held in 1947.

5. No study or essay that has been published in the medical press or elsewhere will be considered eligible for the prize, and a contribution offered in one year cannot be accepted in any subsequent year unless it includes evidence of further work. A prizewinner in any year is not eligible for a second award of the prize.

6. If any question arises in reference to the eligibility of the candidate or the admissibility of his or her essay the decision of the Council on any such point shall be final.

7. Each essay must be typewritten or printed, must be distinguished by a motto, and must be accompanied by a sealed envelope marked with the same motto, and enclosing the candidate's name and address.

8. The writer of the essay to whom the prize is awarded may, on the initiative of the Science Committee, be requested to prepare a paper on the subject for publication in the *British Medical Journal*, or for presentation to the appropriate Section of the Annual Meeting of the Association.

9. Inquiries relative to the prize should be addressed to the Secretary.

### The Katherine Bishop Harman Prize

The Council of the B.M.A. is prepared to consider an award of the Katherine Bishop Harman Prize of the value of £75 in 1947. The purpose of the prize, which was founded in 1926, is to encourage study and research directed to the diminution and avoidance of the risks to health and life that are apt to arise in pregnancy and child-bearing. It will be awarded for the best essay submitted in open competition, competitors being left free to select the work they wish to present, provided this falls within the scope of the prize. Any medical practitioner registered in the British Empire is eligible to compete.

Should the Council of the Association decide that no essay submitted is of sufficient merit, the prize will not be awarded in 1947, but will be offered again in the year next following this decision, and in this event the money value of the prize on the occasion in question will be such proportion of the accumulated income as the Council shall determine. The decision of the Council will be final.

Each essay must be typewritten or printed in the English language, must be distinguished by a motto, and must be accompanied by a sealed envelope marked with the same motto and enclosing the candidate's name and address. Essays must be forwarded so as to reach the Secretary, to whom all inquiries should be addressed, at B.M.A. House, Tavistock Square, London, W.C.1, not later than Dec. 31, 1946.

## POSTGRADUATE NEWS

The Fellowship of Medicine announces: (1) Week-end course in general medicine and surgery, all day Sat. and Sun., April 27 and 28, at Connaught General Hospital, Walthamstow. (2) A series of lectures on the clinical aspects of psychiatry, on Tues. and Wed., at 4 p.m. at West End Hospital for Nervous Diseases, Marylebone Lane, W. (3) Week-end course in gynaecology, all day Sat. and Sun., May 11 and 12, at South London Hospital for Women.

## WEEKLY POSTGRADUATE DIARY

EDINBURGH POSTGRADUATE BOARD FOR MEDICINE.—At Edinburgh Royal Infirmary, Tues., 5 p.m. Prof. F. A. E. Crew: The Biology of Death.

GLASGOW UNIVERSITY: DEPARTMENT OF OPHTHALMOLOGY.—Wed., 8 p.m., Prof. Lowenstein: Ocular Tuberculosis.

## DIARY OF SOCIETIES AND LECTURES

### ROYAL SOCIETY OF MEDICINE

*Section of Urology*.—Thurs., 8 p.m. Clinico-pathological meeting. Cases and specimens will be shown.

*Section of Epidemiology and State Medicine*.—Fri., 2.30 p.m. Meeting at the Wellcome Physiological Research Laboratories, Langley Court, Beckenham. 2.30 to 4.30 p.m. Tour of the laboratories and demonstrations. 5 to 5.35 p.m. Documentary film: Drs. H. J. Parish and A. T. Glenny: The Preparation of Diphtheria Antitoxin and Prophylactics.

*Section of Disease in Children*.—Fri., 5 p.m. (Cases at 4.15 p.m.) WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—At South Kensington Hotel, 41, Queen's Gate Terrace, S.W., 7.30 p.m. Dinner, 8.30 p.m. Dr. John H. Hunt: Indian Fakirs.

## BIRTHS, MARRIAGES, AND DEATHS

The charge for an insertion under this head is 10s. 6d. for 18 words or less. Extra words 3s. 6d. for each six or less. Payment should be forwarded with the notice, authenticated by the name and permanent address of the sender, and should reach the Advertisement Manager not later than first post Monday morning.

### BIRTHS

ANDREWS.—On April 10, 1946, at Bricket House Nursing Home, St. Albans, to Daphne (née Smith), wife of F/O B. E. Andrews, R.A.F.V.R. (now in India), a daughter.

CANE.—On Dec. 24, 1945, at Nairobi, to Margaret, wife of Dr. Hugh Cane, Tanganyika Medical Service, a son.

SCOTT.—On April 1, 1946, to Linden, wife of Major J. B. Scott, R.A.M.C., a daughter.

### MARRIAGES

MILNES—KENNY.—On April 13, 1946, at Goring-on-Thames, Capt. John N. Milnes, R.A.M.C., of Huddersfield, to Deirdre Mary Kenny, of Finchley, London.

STAFFORD—MATTHEWS.—On April 13, 1946, at Edgbaston Old Church, Birmingham, John L. Stafford, M.B., M.R.C.S., to Doreen M. Matthews, M.B., Ch.B.

### DEATH

HENDERSON.—On March 31, 1946, at 16, Wellesley Road, Colchester, J. Randal Henderson, M.B., Ch.B., D.T.M.&H., D.O.M.S., dearly loved husband of Meta Henderson.